

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
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9:30 a.m.

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

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

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

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

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

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

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

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

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

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

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

22 Next, moving to the middle four rows of this

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

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

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

17 Are we missing a slide?

18 DR. AKAMIGBO: [Off microphone].

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

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

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

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

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

1 The first point of this slide is to show that,
2 overall, rural and urban service use is similar. Look at
3 the middle of the slide. Urban use, on average, is 100.5
4 percent of the national average. Rural use, on average, is
5 98.4 percent of the national average. The rural/urban
6 difference is small.

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

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

17 Next we break down service use into three
18 components: inpatient, ambulatory, and post-acute. The
19 first point on this slide is that the mean use of inpatient,
20 ambulatory, and post-acute care are all similar in rural and
21 urban areas. The first circle shows that inpatient use is
22 102 percent of the national average in rural areas. The

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

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

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

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

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

1 similar.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 where the rate is much higher at 16.2 percent.

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

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

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

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

1 satisfaction with access to care.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 The longer driving times by rural beneficiaries

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

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

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

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

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

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

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

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

4 Now we open it up for discussion.

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

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

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

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

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

22 DR. STENSLAND: Correct.

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

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

6 MR. GEORGE MILLER: Right.

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

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

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

14 DR. STENSLAND: This overall usage is risk
15 adjusted.

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

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

20 DR. BAICKER: Okay, so the others are.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 category.

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

6 MR. HACKBARTH: That would be helpful. Thanks.

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

15 DR. STENSLAND: That's correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

21 MR. HACKBARTH: In the MCBS.

22 DR. AKAMIGBO: In the MCBS, yes.

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

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

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

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

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

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

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

1 a little further.

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

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

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

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

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

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

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

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

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

11 DR. AKAMIGBO: The states --

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

15 DR. AKAMIGBO: A metropolitan area.

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

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

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

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

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

6 DR. AKAMIGBO: Right.

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

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

15 DR. AKAMIGBO: Potentially.

16 DR. STUART: Okay. The reason I think that's
17 important is that we have another session that's coming up
18 on benefit design, and if the figure that we see here of
19 16.2 percent of the Medicare population in these areas
20 having Medicare only, having no supplement, then one would
21 expect that you would see some utilization differences in
22 those areas. And so this was the disconnect that I saw,

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

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

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

18 MR. ARMSTRONG: Okay.

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

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

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

6 DR. STENSLAND: Right.

7 MR. ARMSTRONG: Okay.

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

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

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

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

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

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

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

9 MS. UCCELLO: Right, right.

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

13 MS. UCCELLO: Right. Okay.

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

20 DR. STENSLAND: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 DR. DEAN: Fifty visits a year?

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

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

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

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

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

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

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

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

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

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

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

17 MR. GEORGE MILLER: Right.

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

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

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

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

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

12 MR. HACKBARTH: Okay.

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

1 look wider by chance or by particular example.

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

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

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

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

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

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

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

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

6 DR. NAYLOR: Exactly.

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

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

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

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

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

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

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

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

13 MR. HACKBARTH: Are you aware of data sources?

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

1 have nobody to drive you around.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 And then finally, on the paper, and I think it was
15 Page 28 here, there's an interesting bit of information
16 where it talks about the proportion of rural beneficiaries
17 reporting no problem with accessing a new primary care
18 physician, improved from 66 percent in '07 to 83 percent in
19 2010. That's nearly a 20 percent jump over three years.

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

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

3 MR. HACKBARTH: What page again?

4 MR. KUHN: Page 28.

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

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

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

22 MS. BOCCUTI: Thanks. I think improved is not

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

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

15 DR. MARK MILLER: We do have that --

16 DR. HARRISON: [Off microphone]

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

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

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

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

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

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

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

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

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

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

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

1 that PACE is doing in rural settings.

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

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

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

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

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

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

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

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

1 MR. HACKBARTH: Yes. Mitra?

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

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

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

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

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

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

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

22 MR. ARMSTRONG: So given the methodology and the

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

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

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

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

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

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

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

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

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

11 MS. UCCELLO: To tease them out?

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

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

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

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

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

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

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

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

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

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

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

1 to bring people into the store.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And so, I can understand how independents could be

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

4 DR. DEAN: The issue is --

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

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

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

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

15 MR. HACKBARTH: Okay.

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

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

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

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

1 report.

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

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

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

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

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

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

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

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

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

1 disposition of where things stand.

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

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

7 DR. BERENSON: Yeah, okay.

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

11 Kate, you can start whenever you are ready.

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

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

22 First, FQHCs must be located in areas that lack

1 sufficient primary care.

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

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

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

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

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

22 In general, the services provided at FQHCs must

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

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

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

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

1 Patients at FQHCs are disproportionately female
2 among all age groups except for children, which are roughly
3 50-50.

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

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

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

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

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

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

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

20 Total FQHC financing was about \$11.4 billion in
21 2009, roughly half from patient-related revenue and half
22 from grants or other sources. As you can also see from this

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

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

22 I will talk a bit about Medicare's current

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

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

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

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

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

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

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

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

1 the use of limited license practitioners, where appropriate.

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

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

8 MR. HACKBARTH: Questions? Okay, Cori?

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

10 DR. MARK MILLER: Medicare payments.

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

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

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

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

1 to and give a comparison.

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

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

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

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

20 MS. BLONJARZ: That's right.

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

1 MS. BLONJARZ: That's right.

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

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

10 MR. ARMSTRONG: Yes.

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

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

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

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

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

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

6 MS. BEHROOZI: I'm not sure where this question is
7 going to go, but in reading the paper, with respect to the
8 picture of the population served at FQHCs, with respect to
9 the rate of chronic disease, you note that the patient
10 population at FQHCs tends to have more chronic diseases than
11 the general public, I guess, but it just seemed a little
12 low, what's reported here. Four percent had asthma. I
13 think our population is closer to ten, actually, in, like,
14 New York City in general, and six percent had diabetes. I
15 actually just looked at an article this morning that said
16 West Chester County in New York is the best county in New
17 York State with respect to health status, and their best is
18 6.6 percent.

19 MS. BLONIARZ: Right.

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

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

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

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

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

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

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

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

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

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

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

22 DR. STUART: And is there any other source of

1 information about them?

2 MS. BLONJARZ: Not that I've easily found.

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

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

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

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

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

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

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

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

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

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

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

17 MS. BLONJARZ: It's a mandatory appropriation, as
18 well.

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

1 for --

2 MS. BLONIARZ: That's right. I think the House-
3 reported appropriations bill would reduce funding by about
4 \$1.5 billion, so it would be in the range of \$500 to \$700
5 million remaining.

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

8 MS. BLONIARZ: Yes.

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

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

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

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

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

12 One of the things that concern me is that on page
13 15 in the material that you sent out, you said that the
14 chronic care management of FQHCs are found to be equal in
15 comparable facilities serving this underserved population,
16 but when you compare it to community-served population, it
17 was a lot less, and that concerns me about quality. Any
18 information, clarification on that?

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

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

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

15 DR. CASTELLANOS: Thank you.

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

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

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

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

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

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

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

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

20 MS. BLONJARZ: So no new FQHCs can be facility-
21 based.

22 DR. KANE: Yes.

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

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

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

9 DR. KANE: It's the governance piece.

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

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

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

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

8 MS. BLONJARZ: That's right.

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

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

16 MR. HACKBARTH: Okay.

17 DR. KANE: Yes.

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

22 MS. BLONJARZ: [Off microphone.] Yes.

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

3 MS. BLONJARZ: [Off microphone.] Yes.

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

6 DR. KANE: So it wouldn't be linked to Medicare,
7 it would actually come without being linked to some Medicare
8 --

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

13 MS. BLONJARZ: Right.

14 MR. HACKBARTH: Peter?

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

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

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

1 big, or something like that.

2 MS. BLONJARZ: Something, or serving twice as many
3 patients.

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

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

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

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

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

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

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

6 MR. HACKBARTH: I'm sorry, George?

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

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

12 MR. GEORGE MILLER: Right.

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

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

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

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

10 DR. NAYLOR: Right.

11 MS. BLONJARZ: But that's the aggregate number for
12 the first year of the PPS.

13 DR. NAYLOR: Thanks.

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

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

1 forward?

2 MS. BLONJARZ: Those are both two things that we
3 should look into.

4 MR. GEORGE MILLER: Okay.

5 MS. BLONJARZ: Yes.

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

21 MR. HACKBARTH: Do FQHCs ever dispense
22 pharmaceuticals?

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

3 MR. HACKBARTH: Round two comments? Tom?

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

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

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

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

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

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

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

1 centers and that we desperately need.

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

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

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

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

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

22 DR. BERENSON: Just to pick up a couple of

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

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

16 MR. KUHN: A couple quick questions. One is a
17 little bit what others have kind of spoken to as we move to
18 2015 and the new PPS system, and if I heard right, it will
19 probably pay more than is currently there. So in this
20 transition period between now and then, are there any
21 incentives for FQHCs to try to constrain costs in Medicare,
22 or what happens between now and 2015?

1 MS. BLONJARZ: Not as far as I know in terms of
2 the legislative language.

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

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

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

1 PPS?

2 MS. BLONJARZ: I don't believe so.

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

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

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

12 MR. HACKBARTH: Right. Right.

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

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

15 DR. MARK MILLER: Did I misstate that?

16 MS. BLONJARZ: No, that's right.

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

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

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

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

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

17 MS. BLONIARZ: Sure. Absolutely.

18 DR. CASTELLANOS: I would appreciate it.

19 MS. BLONIARZ: Absolutely.

20 DR. CASTELLANOS: Thank you.

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

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

7 And so I'm just wondering if it's wise to think
8 about this as some great place for Medicare people, which
9 historically this has not been, or whether it's really --
10 okay, it's good that Medicare is finally going to pay more
11 than at least its cost, given that otherwise we're
12 subsidizing with these grants that are meant to serve the
13 uninsured, but do we really want to encourage more Medicare
14 people to go to FQHCs or do we just want to make sure
15 Medicare is not adding to the burden? I mean, I think we
16 just need to think about what's the goal of having Medicare
17 patients in FQHCs, because they really aren't, except for
18 maybe in rural areas -- and I think Tom's right. There's a
19 difference, maybe, between rural and urban, but I know that
20 --

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

1 DR. KANE: I think the urbans are different.

2 DR. DEAN: Urban CHCs are primarily safety net
3 providers

4 DR. KANE: They really are.

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

7 DR. KANE: Yes.

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

10 DR. KANE: Yes.

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

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

15 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 But thanks again for a great report.

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

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

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

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

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

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

14 And now we'll have our public comment period.

15 [No response.]

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

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

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AFTERNOON SESSION

[1:02 p.m.]

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

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

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

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

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

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

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

1 design.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 Let's take the first bar in the chart. There are
19 actually three separate data points packed in there. The
20 height of the bright yellow part of the bar is the median
21 share for high-income beneficiaries, defined here as above
22 200 percent of poverty, and that's about four percent. If

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

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

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

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

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

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

7 DR. SOKOLOVSKY: There is an extensive literature
8 on the effects of cost sharing on the use of health care
9 services. The RAND Health Insurance Experiment remains the
10 gold standard on the subject. This was a large-scale
11 randomized trial conducted between 1971 and 1982. More than
12 7,700 people participated in it, all of them under 65.
13 Among the most important conclusions, cost sharing reduces
14 the use of both necessary and unnecessary services. Cost
15 sharing had no adverse effect on most participants, but
16 there were exceptions among the poorest and the sickest.
17 Once individuals decided to get care, cost sharing had only
18 a small effect on the extent or cost of an episode of care.
19 Later research that focused on Medicare beneficiaries found
20 that those with supplemental coverage tended to have higher
21 service use. However, the effect of the increased use
22 remains controversial.

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

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

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

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

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

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

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

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

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

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

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

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

22 Two interviewees pay for enrollees with serious

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 forward.

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

4 [Laughter.]

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

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

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

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

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

10 MR. BUTLER: [Off microphone.] Can we go to Slide
11 10? You know, we've heard the RAND study cited many times
12 here and I haven't read it. But we know that the copays
13 work and coinsurance work, but I'm less clear about how they
14 define what's necessary and unnecessary services. Can you
15 talk a little bit more about how that's done?

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

1 DR. MARK MILLER: What I would say, and anybody
2 who is deeper than this over there can speak up, but they
3 used clinical consultants to sort of look at vignettes of
4 services and then classified them from necessary to
5 unnecessary. The difficult thing about it is if you look at
6 it very carefully, there is like a small band that was
7 defined as clearly necessary, clearly unnecessary, and then
8 a bunch of stuff that was defined as not so clear. But I
9 think, and this is where I could use some help, the
10 assertion that it affects both necessary and unnecessary
11 were the effects on tails or it was that it had pretty much
12 an effect across the band of services. But Kate, maybe you
13 --

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

1 changes in their health associated with the utilization.

2 But most other populations, it was too small to observe.

3 MR. BUTLER: Okay. Here's the reason I'm asking,
4 among others. We have a slide, also, that shows how there
5 are no -- this ridiculous copay for hospital care the first
6 day, which seems like it is necessary, yet, you know, and so
7 we -- I'm trying to think ahead and where you would put your
8 copays and deductibles, and if we kind of just take, for
9 example, hospital off the list, I could say, well, what
10 about a joint replacement that maybe is questionable for a
11 90-year-old that goes into the hospital. How do we factor
12 those kinds of things into it? My guess is that RAND didn't
13 get into that kind of differentiation.

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

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

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

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

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

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

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

22 DR. KANE: Encounter data.

1 [Laughter.]

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

6 MR. HACKBARTH: Yes.

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

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

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

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

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

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

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

3 [Laughter.]

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

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

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

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

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

3 DR. CASTELLANOS: Okay.

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

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

9 MR. HACKBARTH: Herb?

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

16 DR. SOKOLOVSKY: Yes.

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

19 DR. SOKOLOVSKY: Yes.

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

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

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

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

22 DR. SOKOLOVSKY: Yes.

1 MR. KUHN: Thank you.

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

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

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

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

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

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

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

6 DR. HARRISON: I think K and L are seen as very
7 complicated. When people try to sell them to the
8 beneficiaries, it's a very complicated design structure and
9 they don't know what 25 percent of usual coinsurance is. I
10 think there's more hope in the new Plans M and N,
11 particularly N, which is a set copay for physician services,
12 \$20 for a physician office visit and up to \$50 for an
13 emergency room visit, and I believe the industry is
14 optimistic that those are going to be selling.

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

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

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

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

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

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

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

14 DR. BERENSON: Okay.

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

1 DR. SOKOLOVSKY: Yes.

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

8 DR. SOKOLOVSKY: Yes.

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

11 [Laughter.]

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

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

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

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

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

1 really important.

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

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

9 [Laughter.]

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

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

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

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

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

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

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

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

16 DR. MARK MILLER: Yes.

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

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

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

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

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

14 MR. HACKBARTH: Scott?

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

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

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

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

18 MR. HACKBARTH: Right.

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

1 themselves, although I don't know.

2 I mean, we've talked about some of this benefit
3 design work may be informed by looking at what MA plans are
4 already doing, but it seems to me you'd want to start out
5 with just some slightly more objective comparator between MA
6 on these bases with the way in which we've done this
7 analysis already. So --

8 DR. BERENSON: I would just point out that I'm all
9 for doing the analysis, but MA plan has had a lot more money
10 to play with to have a more generous benefit package, so
11 that has to be taken into account with any comparison like
12 that.

13 MR. ARMSTRONG: Well, you're talking about a ten
14 percent or so cost differential. Well, I think it would be
15 interesting to see how that compares with straight-up fee-
16 for-service or straight-up fee-for-service with the cost of
17 the Medigap premium.

18 MR. HACKBARTH: I'm not sure if this is what
19 you're getting at, Scott. When we do our comparisons of MA
20 plans to traditional Medicare, what we use is the bids for
21 the standard Medicare benefit package. So we don't compare
22 different benefit packages. So we compare HMOs as a type of

1 MA plan, what is their bid on the basic Part A and B benefit
2 --

3 MR. ARMSTRONG: Right.

4 MR. HACKBARTH: -- to what it costs Medicare to
5 provide that same basic A and B benefit, and the answer
6 comes out, like, HMOs, on average, have 97 -- their bids are
7 97 percent of the cost of traditional Medicare. That is an
8 apples-to-apples comparison. Is that what you're trying to
9 get at?

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

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

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

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

6 MR. HACKBARTH: [Off microphone.]

7 MR. ARMSTRONG: Okay.

8 MR. HACKBARTH: [Off microphone.]

9 MR. ARMSTRONG: Okay.

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

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

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

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

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

9 MR. HACKBARTH: Right.

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

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

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

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

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

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

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

1 really important. The income differences seem like they
2 should be exaggerated among those with income greater than
3 200 percent because that's such a big range. So then if you
4 just look at the income below 200 percent, you're still
5 seeing that surprising gap in Medigap protection, which is
6 part of why I was wondering if it's more about health
7 selection. If it's not selection based on income, because
8 we've made a pretty narrow income range, maybe it's
9 selection based on health.

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

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

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

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

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

13 DR. MARK MILLER: Scott?

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

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

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

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

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

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

10 DR. MARK MILLER: So --

11 DR. KANE: [Off microphone.]

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

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

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

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

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

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

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

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

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

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

17 DR. MARK MILLER: Okay.

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

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

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

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

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

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

21 Round 2 comments, beginning with Karen.

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

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

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

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

22 I think in that discussion, however, in fairness

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

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

15 But I will say that I think this conversation
16 about benefit design and the conversation about what the
17 21st century beneficiary looks like and what that population
18 is are the two most important things at the end of the day
19 that we probably work on as longer term issues. And so, I
20 fully support this and staff is coming at it in the usual
21 wonderful way.

22 I just think we need to make sure that as we

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

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

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

22 Of course, a very different sort of exercise is,

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

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

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

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

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

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

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

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

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

22 And it reminds me of some patient reactions to

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

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

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

19 MR. HACKBARTH: After 15 years.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 MR. HACKBARTH: Ron?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 not spend any more money.

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

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

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

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

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

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

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

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

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

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

1 the Health Systems Management Plan database.

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

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

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

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

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

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

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

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

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

9 MR. HACKBARTH: Yes.

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

14 MR. HACKBARTH: That's true.

15 DR. STUART: That's standard for everybody.

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

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

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

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

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

5 And, you know, on the non-Medicare side now, under
6 PPACA, it's up to 400 percent of the poverty level where
7 people could get a subsidy to pay for -- to put some of
8 their own resources into getting that coverage. So I think
9 that yeah, bringing it back into Medicare's design to
10 address the problem of catastrophic coverage is not the most
11 efficient way of doing it, but address the problem for that
12 10 percent of people.

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

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

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

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

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

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

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

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

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

22 But I would caution against getting too

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 intermediate, and long-term questions. I think we could
2 tackle them in that order and say, you know, let's work on
3 these short-term questions, see if we think there is grounds
4 here for some recommendations, and then if not or even if
5 the answer is yes, then move on to the intermediate issues
6 and so on.

7 But I think we can't jump around these lists. The
8 issues are too complex to try to do that. I see some people
9 nodding that that makes sense. I see Mitra pursing her
10 lips.

11 MS. BEHROOZI: I just feel like when we do the
12 updates, we rail against the silos and so I get that there's
13 a lot of complex issues, but I guess maybe it's a matter of
14 staging things or whatever. But I feel like you can't
15 analyze them separately. You know what I mean? And having
16 a discussion about them separately is difficult.

17 MR. HACKBARTH: Yeah, yeah, well, there certainly
18 is inner play among them. Part of my thinking here is this
19 is the March meeting, albeit in February. We have one more
20 meeting this cycle and then we don't see each other for
21 several months. We have the retreat and then another month-
22 and-a-half, almost two months, before we meet again.

1 It's very difficult on a multi-faceted set of
2 topics to maintain continuity in the conversation. I would
3 think that we will get more traction and move more quickly
4 if we bite off a piece, focus on it, acknowledge that it
5 relates to other issues and we can say, we want to flag that
6 and pick it up next time when we get to intermediate issues,
7 but I think we've got to break this somehow.

8 MR. ARMSTRONG: Just a brief comment on your
9 proposal. If you look at Pages 17, 18, and 19, or whatever
10 they are, it will be hard to really focus on the short-term
11 without talking about -- if you're trying to rationalize
12 cost-sharing without talking about, well, are we talking
13 about cost-sharing that relates to different providers or
14 different benefits?

15 I mean, I think when we get in a little bit more
16 specific, we'll be able to structure the starting with the
17 short-term stuff, but it will get into some of the second
18 page and third page issues as we do it.

19 MR. HACKBARTH: Yeah.

20 MR. ARMSTRONG: So I would avoid trying to be too
21 precise about how we structure right now, and as we get into
22 it, I think we'll solve some of those.

1 MR. HACKBARTH: Okay. Well, let us put our heads
2 together and think about what might be an orderly approach
3 into this array of topics. Thank you, Joan and Julie. Very
4 provocative stuff and a productive discussion.

5 Next up today is the Sustainable Growth Rate
6 system. We have Cristina and Kate and Kevin.

7 [Pause.]

8 MS. BOCCUTTI: Okay. Well, as most of you know,
9 policymakers are facing an extremely difficult challenge
10 regarding Medicare's payments for physician and other health
11 professional services.

12 Under the current law, Medicare's fees for these
13 services are scheduled to decline more than 30 percent over
14 the next several years, as required by the SGR.

15 So today we're going to give a very brief
16 background on the SGR, and then we're going to raise some
17 policy issues that are associated with it, namely,
18 discussing problems with the SGR, examining issues related
19 to expenditure targets in general, and, finally, discuss
20 some alternatives that have been proposed. And Kate and
21 Kevin have a little bit of new data to bring for a couple of
22 those proposals, so we'll spend a little more time on that,

1 and then, of course, open it up for you all to discuss some
2 of the issues and possible directions.

3 So starting with a quick definition of the SGR,
4 it's Medicare's formulaic method for annually updating
5 services furnished by physicians and other health
6 professionals. It was designed to keep aggregate Medicare
7 spending for these services on a "sustainable" or affordable
8 trajectory. So in doing that, it tied allowed volume growth
9 to our nation's GDP and set a target that way.

10 The SGR was established by the BBA, but keep in
11 mind that expenditure targets have been a part of the
12 physician fee schedule since its inception. And we went
13 over a lot of the details about how the SGR formula works,
14 and we can answer questions about that. But it was in your
15 chapter or draft.

16 Moving on, to discuss what updates the SGR formula
17 has produced. In early years, volume growth was below per
18 capita GDP, so updates were at or above MEI, in accordance
19 with the formula. In later years, volume growth increased
20 and per capita GDP slowed, creating an ever-increasing
21 discrepancy between the actual and the target spending.

22 So, given that, the SGR has called for rate cuts

1 every year since 2002. But since 2003, Congress has passed
2 a series of bills to override these cuts, and the resulting
3 annual updates from these overrides have been fairly modest.
4 And I would say although this year we had a payment increase
5 of a little more than 2 percent for half the year, the
6 overrides have all been under 2 percent.

7 The next scheduled cut, of course, is for January
8 2012, and that will be likely 25 percent or greater.
9 Certainly not less than that.

10 So why does it cost so much to "fix" the SGR?
11 Given the widespread agreement that such a deep cut -- and
12 multiple cuts over consecutive years -- can have detrimental
13 effects on access it does seem counterintuitive that
14 Congress has not been able to make long-term adjustments to
15 the SGR to bring it more in line with realistic updates.
16 But as you recall from the previous discussions, the main
17 obstacle is budget scoring.

18 So, for example, a ten-year freeze -- that is, a 0
19 percent update for 10 years -- scores at about \$276 billion.
20 It's even more for a ten-year MEI update. And these numbers
21 are expected to grow when CBO releases new scores. The
22 upshot is that fixes with these kinds of updates would have

1 to be paired with offsets in federal spending.

2 So what's driving these costs? First, future
3 positive updates or even freezes have to make up for deep
4 cuts each and every future year in the ten-year window.
5 And, second, the formula requires previous excess spending
6 to be recouped also caused issues, particularly for the
7 first three years of overrides. It compounded the amount
8 that the SGR had to recoup.

9 And, finally, there are other cost ramifications
10 for higher updates. You've got spending for the Medicare
11 Advantage program and TRICARE would also increase because
12 their payment levels are tied to the fee schedule and other
13 fee-for-service spending. And, also, Medicare Part B
14 premiums would increase to cover the share of Part B
15 expenditures.

16 Moving on to broader policy implications, previous
17 Commission discussions have reiterated several widely held
18 criticisms and flaws of the SGR system. A main flaw is its
19 inability to differentiate updates by provider. It neither
20 rewards specific physicians or other health professionals
21 who restrain unnecessary volume growth nor penalizes those
22 who contribute most to volume increases. And a second

1 problem is that the SGR is strictly budgetary. It has no
2 tools to counter the volume incentives inherent in fee-for-
3 service payment systems or improve quality.

4 So in addition to these systemic flaws, there is
5 widespread agreement that the updates that the SGR formula
6 has produced are also problematic. Large, looming negative
7 updates threaten provider willingness to serve Medicare
8 beneficiaries and, thus, also threaten beneficiary access.
9 Also, the temporary, stop-gap "fixes" that have been
10 implemented create uncertainty, frustration, and financial
11 problems for medical providers. And, additionally, these
12 stop-gap measures add significant burden to CMS resources
13 and their claims-processing activities.

14 I also want to bring up some considerations for
15 expenditure target issues in general. So when examining the
16 concept of expenditure target systems, the Commission has
17 stated several points:

18 First, expenditure targets may constrain price
19 growth, but their effect on spending, or volume, is less
20 direct.

21 Nonetheless, expenditure target systems, by
22 design, regularly alert policymakers of spending growth, and

1 they do require significant congressional effort to override
2 them. And as the Commission has stated repeatedly,
3 expenditure target systems in their starkest form are not a
4 mechanism for improving care quality or even care
5 efficiency.

6 And, finally, expenditure targets that are
7 narrowly applied to a single sector, such as fee schedule
8 spending, offer no spending flexibility across provider
9 sectors.

10 So now we're going to discuss several proposals
11 that policymaker and analysts have raised in the past
12 several years regarding SGR alternatives. I'll start with
13 two proposals for technical changes to reconfigure the SGR
14 formula. In general, their goals are to: smooth out the
15 updates and reduce the extent of negative updates.

16 The first change would amend or eliminate the
17 cumulative aspect of the SGR which led to, of course, the
18 growing "hole" that takes multiple years of negative updates
19 to recoup.

20 If annual targets instead were used, excess
21 spending that is not recouped within one year would be
22 forgiven. We would have a different picture with regard to

1 the hole.

2 Another option is to implement an additional
3 allowance corridor around the spending target line. This
4 option would relax the precision of the spending target and
5 only trigger a negative update when the difference between
6 actual and target spending exceeds a specified corridor. I
7 usually have a hand diagram for "corridor." I'm bumping the
8 microphone here.

9 But moving on to the advantages and the
10 disadvantages -- the disadvantage, of course, is my hand
11 motion, but I'll leave that aside. The main advantage of
12 the technical adjustments that I just mentioned is that they
13 suppress the extent of negative and positive updates, but
14 they also would restrain spending and have expenditure
15 control mechanism as part of them. And they could be
16 implemented relatively quickly -- that is, compared to some
17 of the other alternatives that we will be discussing in a
18 minute.

19 However, the disadvantages of these approaches is
20 that to the extent that they forgive any spending above the
21 target, they will be more costly than current law. And,
22 also, the technical changes don't offer incentives for

1 improving care quality or efficiency.

2 Kevin is going to move on to talk about some types
3 of service.

4 DR. HAYES: A type-of-service SGR is one in which
5 a target growth rate and update are calculated and applied
6 separately for each service category. A rationale for a
7 type-of-service SGR would be, one, that it accounts for
8 volume growth that varies by type of service; and, two, it
9 might also restrain prices for services that are overpriced.

10 Different strategies have been developed for
11 structuring a type-of-service SGR. In terms of how services
12 would be grouped, we see that one proposal had two
13 categories. E&M and preventive services were in a category,
14 and then all other services were in another category.

15 Then previously there had been a proposal to look
16 at a category scheme that included six types of services, so
17 we would have primary care separated out from other E&M
18 services and then four other categories: imaging and tests
19 in a category, major procedures, minor procedures, and
20 anesthesia.

21 Note that by itself a type-of-service SGR would
22 not solve the SGR scoring problem. For example, if the

1 decision was to have a hold harmless, say, for one type of
2 service while still meeting the current requirement of an
3 overall reduction of at least 25 percent; other services
4 would have to make up for the hold harmless. Their
5 reduction would become larger than minus 25 percent.

6 Rebasing would reset the spending targets and
7 avoid the negative update for 2012, but the cost would be
8 considerable. CBO has scored the ten-year cost of rebasing
9 at \$194 billion. Beyond rebasing, a decision for a type-of-
10 service SGR is where to set the volume allowances. Options
11 considered have included the current allowance of growth in
12 real GDP per capita. Another option considered has been to
13 raise that allowance by a percentage point or two. Of
14 course, raising the allowance has spending implications.

15 To analyze the type-of-service SGR, we asked:
16 One, how might the updates vary by type of service? And,
17 two, how might the updates change depending on the allowance
18 for volume growth?

19 For the analysis, we put practitioner services
20 into five categories, the ones that you see here on the
21 slide: E&M, imaging, major procedures, other procedures,
22 and tests. Of course, other structures are possible,

1 including a separate category, say, for primary care.

2 We considered different levels for the volume
3 allowances. The one shown on the slide is growth in real
4 GDP per capita plus a percentage point. That's for all
5 services. Comparing that allowance to recent growth in the
6 volume of services, we see that volume growth for all
7 services exceeded the allowance.

8 In the case of E&M and major procedures, the
9 differences were between 1 and 1.5 percentage points. In
10 the case of other services, the differences were between 3
11 and 4 percentage points.

12 For a rough approximation of updates, we can
13 subtract these amounts from the MEI of 1 percent. That's
14 the preliminary forecast of the MEI for 2012. Doing so, we
15 get updates in a range from 0 to minus 3 percent.

16 The takeaway is that with rebasing, with the
17 volume allowance greater than growth in real GDP per capita,
18 negative updates are still possible is volume growth exceeds
19 the volume allowances.

20 From the Commission's 2007 SGR report, one
21 advantage of a type-of-service SGR is that it recognizes
22 that volume growth varies by type of service. Another

1 advantage is that type-of-service targets and deviations
2 from them may signal that practitioner services are
3 mispriced. A disadvantage is that an update adjustment
4 would be applied to services regardless of who ordered them,
5 an issue of accountability.

6 A second concern might be that physicians will
7 shift their provision of services from one type of service
8 to another to avoid negative payment adjustments.

9 And a third issue to be aware of is that spending
10 in a service category could go up for reasons other than
11 volume growth. For example, CMS changes relative values in
12 a fee schedule periodically because of changes in methods
13 and data. When that occurs, spending for a service category
14 may go up. Should the type of service SGR then reduce
15 payments for the service category? Probably not.

16 Cristina will now address some other SGR
17 alternatives.

18 MS. BOCCUTTI: So another alternative that has been
19 getting some attention is to exempt certain providers from
20 the current SGR target. The providers that would be
21 eligible under this kind of policy might be affiliated with
22 organizations that have structures that are very well suited

1 to manage the health and spending for a population. So, for
2 example, physicians and other professionals who are
3 affiliated with an ACO or a medical home might be candidates
4 for this kind of exemption policy.

5 Of course, CMS is right now in the process of
6 determining how to measure quality and spending for these
7 organizations. But think about it as having the SGR
8 exemption for practitioners only granted if their affiliated
9 ACO or medical home did share some risk. So, of course,
10 they would be affiliated with organizations that could get
11 bonuses or penalties based on performance.

12 Advantages of these kinds of policies are that
13 with them there is the opportunity of escaping the SGR for
14 those eligible, and that may be an important factor in
15 gaining provider participation in needed delivery system
16 reforms. Also, in exempting these providers, these policies
17 would promote efficient, team-based care and comprehensive
18 patient care management.

19 And third is that another advantage is that the
20 policy creates a somewhat more individualized spending
21 target and result in this model. But, of course, there are
22 some disadvantages that come to mind.

1 These exemption policies would be complex to
2 administer; they would require layers of further operational
3 issues, such as provider eligibility, selecting performance
4 measures, et cetera.

5 Also it's hard to predict, participation rates,
6 which, of course, has implications on the available funding
7 for those that are exempt and for those who would not be
8 exempt.

9 We're moving on to Kate.

10 MS. BLONIARZ: I'll talk about an outlier
11 alternative that would identify physicians who, as compared
12 with their peers, use significantly more resources.

13 At a very granular level, the variation in
14 physician resource use is quite notable, exceeding the
15 variation seen when comparing Medicare service use across
16 MSAs. Even when physicians are compared only to others in
17 their specialty and MSA who treat the same type of case,
18 resource use at the 90th percentile can range from 40 to 90
19 percent above the average for their specialty in an MSA.

20 An illustrative outlier policy could have the
21 following general structure:

22 First, a physician's resource use would be

1 compared to their peers within the same MSA and specialty.

2 Second, the outlier policy could focus on
3 physicians who persistently use more resources than their
4 peers. Using an episode-based analysis, we found that among
5 those physicians in the top ten percentile of resource use
6 in 2007, 27 percent were outliers for the second year in a
7 row. However, 9 percent were outliers for the fourth year
8 in a row. The outlier policy could, therefore, focus on
9 these persistent outliers.

10 Third, the policy could use both low- and high-
11 impact interventions for outlier physicians. For example,
12 the policy could provide actionable feedback to the outlier
13 physician that their resource use is higher than their
14 peers. If the outlier physicians' patterns did not change,
15 a high-impact intervention, such as a penalty, could be
16 applied.

17 We know that one significant concern with episode-
18 based analyses of resource use is that an individual
19 physician may appear to be very efficient on an episode
20 basis, but may be generating a lot of episodes.

21 We looked at the overlap between per capita
22 measures and episode-based measures and found that between

1 60 and 70 percent of physicians identified as outliers based
2 on an episode analysis were also outliers based on per
3 capitas. The outlier policy should use both episode and per
4 capita measures to ensure that the full picture of physician
5 resource use is being captured.

6 The advantage to having an outlier policy is that
7 it targets the interventions to those physicians who are
8 contributing the most to Medicare spending growth. spending
9 growth unlike the SGR which applies a reduction to all
10 physicians. And using both episode and per capita methods
11 can give a more complete picture of resource use.

12 Among the disadvantages of an outlier policy are
13 that, first, there are a number of methodological issues in
14 designing an episode-based analysis of physician resource
15 use.

16 Second, resources will be required to build and
17 maintain a transparent Medicare-specific episode grouper
18 that holds sufficient validity with physicians and other
19 stakeholders.

20 And, third, while outlier physicians may
21 correspond to a disproportionate share of spending, by their
22 definition they only constitute a small share of the

1 physician workforce.

2 Turning back to Cristina.

3 MS. BOCCUTTI: Okay. I'm going to take just a
4 minute to talk about some ongoing work that we're doing
5 because you all have raised a number of these issues.

6 So before we get back to the SGR, I'm going to
7 note that we have ongoing contracts with two contractors on
8 the topic of valuation of practitioner services. One
9 project is about validating the fee schedule time estimates
10 and related data collection issues. And the second project
11 explores alternative approaches to valuing practitioner
12 services rather than straightforward RVU-based payments.
13 We're going to have more to say about those projects at the
14 April meeting, so stay tuned. But we can answer questions
15 about that, if you like.

16 So here's the final slide we have for our
17 presentation that lists these two issues. We've sort of
18 whittled them down to two fundamental issues here, of
19 course, the first being scoring, and even though future cuts
20 of more than 25 percent and beyond are unrealistic,
21 eliminating them requires significant offsets in federal
22 spending.

1 The other fundamental issue is creating better
2 policy. Medicare needs to structure a payment system for
3 physicians and health professionals that rewards quality and
4 efficiency, while also improving payment equity among
5 providers. And, of course, there's the question of whether
6 expenditure targets should be a piece of future policy. And
7 finally, of course, you may want to weigh the advantages and
8 disadvantages of the proposals that we have just brought up
9 today.

10 Thank you.

11 MR. HACKBARTH: Okay. Thank you all for that.

12 Before we start the rounds of questions and
13 comments, I wanted to add a little bit more about the
14 context for this issue and also a way -- I don't have
15 specific proposals about how to solve this very difficult
16 problem, but I do have some thoughts about how to think
17 about a possible direction to move out. And I'll ask Bob to
18 chime in on this as well. But let me just quickly review
19 some history here.

20 Of course, the SGR was enacted in 1997 as part of
21 BBA. In 2001, MedPAC recommended repeal of SGR, citing the
22 sort of problems that Cristina describes, fundamental

1 problems in the design that we thought at the time meant
2 that it would be unlikely to achieve the desired results and
3 inevitably cause problems. In fact, things have played out
4 in that way.

5 Of course, the issue very quickly became the
6 rapidly increasing budget score attached to repeal, and even
7 with the problems starting to manifest themselves, many of
8 us thought that potentially the benefit of SGR, despite its
9 manifest problems, was that it did create some pressure to
10 hold down the year-to-year increases in the conversion
11 factor, and that was a budgetary benefit to the program.

12 The way I've been inclined to look at SGR is look
13 at the costs and benefits of the system as it has rolled
14 along these past ten years. And, okay, on the benefit side,
15 some pressure to hold down increases and updates, we'll
16 chalk that up as a potential benefit. What worries me is
17 that the cost side of the ledger is growing, and in previous
18 conversations that we've had as a commercial, sort of the
19 chief concern is that the instability in the system
20 threatens access to quality care for Medicare beneficiaries;
21 that the increasingly rapid cycle of having to wrestle with
22 how to offset the costs and what's going to happen if we

1 can't come up with a package to avoid the next 25-percent
2 cut, that drama as it plays out here has ramifications for
3 the Medicare patient population and for the physicians who
4 serve them. In short, this increasingly rapid cycle is
5 undermining confidence in the program, both among
6 beneficiaries and physicians.

7 So that's a very significant cost of continuing on
8 year after year as we are against the benefit, potential
9 benefit of lower increases in the updates.

10 Well, that situation I think is destined to
11 deteriorate still further in the future. The benefit of
12 pressure on updates, frankly, there's going to be pressure
13 on updates even if SGR doesn't exist because of the overall
14 budgetary situation. There will be other ways, other
15 reasons to be very cautious and conservative about updates
16 in the fee schedule. I don't think we're any longer, for
17 better or worse, dependent on the SGR for that sort of
18 pressure.

19 As this score increases, what that means is that
20 finding the offsets to allow even short-term extensions
21 becomes more and more difficult in each cycle, which is one
22 of the reasons why the extensions seem to have gotten

1 shorter and shorter and we go through this drama more and
2 more frequently all the time. These scores are just going
3 to keep going up and up and up, and so that problem is going
4 to become worse and worse over time.

5 So my fear -- and based on previous conversation,
6 I think it's one shared by the group -- is that we're in a
7 deteriorating situation here. We're spiraling down. This
8 isn't going to get better. This is destined to get worse.

9 The score, however, is a huge problem. In a way,
10 it, too -- that problem has gotten worse recently. In
11 PPACA, there is a long list of Medicare savings to the tune
12 of roughly \$500 billion over ten years, some of which are
13 based on previous MedPAC recommendations.

14 Basically, all of the prominent Medicare savings
15 opportunities were used in PPACA for a different purpose --
16 to fund the extension of benefits or move towards universal
17 coverage. So those dollars are not now -- those Medicare
18 savings ideas are not now available as potential offsets to
19 the SGR score. So what was always a steep climb to find
20 offsets has become steeper still because so many of the
21 ideas have been used.

22 I fear that the bottom line is that there are not

1 Medicare offsets, at least that I can think of, for this
2 large and rapidly growing score attributable to repeal. And
3 that bothers me because if it doesn't come from Medicare,
4 that means it's going to come from someplace else, and I
5 already worry about how our health programs are eating up
6 the Federal budget and devouring resources that are needed
7 for other programs. And so this is very troubling to me.

8 Having said that, if we choose as a group to
9 recommend if not a repeal of SGR, a major restructuring or
10 resetting of SGR, and we can't come up with all of the
11 offsets necessary, I think it is possible to use that
12 legislative event as an opportunity to achieve some major
13 goals in physician payment that might be difficult to
14 achieve otherwise, and let me speak frankly here.
15 Physicians, many physicians, value highly getting rid of
16 SGR. They might be willing to accept some changes in
17 physician payment that otherwise would be politically
18 infeasible if it were a part of a desirable package. So
19 even if we can't offset the score, this may be an
20 opportunity to achieve some very important ends in
21 restructuring the physician payment system that would
22 otherwise be beyond our reach. So in that sense, you know,

1 always looking for the pony in the manure, that's my pony in
2 this particular pile of manure.

3 So what are some examples of those things? I'm
4 going to lay out some ideas. Certainly I'm not speaking for
5 the Commission here. In fact, I'm not even sure I'm
6 speaking for myself on all of these ideas, but they are
7 ideas that come to mind.

8 So you can imagine a repeal bill becoming an
9 opportunity to say let's do a major reset in terms of the
10 structure of Medicare physician fees. We often talk about
11 the need to reward some specialties that are critically
12 important, more than they are now. MedPAC has always
13 advocated doing that in a budget-neutral way, so it means
14 more for some, less for others. This kind of legislative
15 vehicle could be a rare opportunity to do that sort of
16 significant redistribution of payments within the physician
17 system.

18 One way to do that would be a cut in the
19 conversion factor with significant bonuses for some
20 specialties and services. It would be very difficult to do
21 that in other contexts. It may be possible to do it in this
22 context.

1 Another category of ideas has to do with volume
2 restraints. Our next topic is in-office ancillary expenses
3 and our concern about what has been happening there.
4 Incidentally, some people would say some of what has been
5 happening here is a by-product of SGR to some extent. If we
6 could have a package that went aggressively after some of
7 the issues that have arisen in in-office ancillary as part
8 of that, it would be very difficult to enact in a different
9 context, but maybe as part of an SGR package that might be
10 much more feasible as part of a quid pro quo.

11 Another idea would be -- and here, Bob, I'm going
12 to turn to you -- that you could keep some fashion of a
13 target, perhaps reset with a new rate of growth target as an
14 action-forcing tool in the physician payment system. As
15 opposed to it being a trigger for formulaic across-the-board
16 cuts, it could be an action-forcing tool for changes in
17 relative values. So the Secretary could be compelled to act
18 in order to try to hit this new target, and so it's not an
19 automatic thing. You have a decisionmaker who says if
20 that's the target, here's what I need to do to revalue fees,
21 restructure the physician payment system.

22 DR. BERENSON: Well, you've basically said what I

1 would say, but let me just do it in a few different words.

2 One of the problems that I've had with the SGR-
3 type mechanism, and before that the volume performance
4 standard, was that it was a mechanistic, formula-driven
5 reduction across the board, regardless of which services
6 were driving volume and regardless of where informed people
7 thought that there were distortions in the payment rates.

8 So I think the suggestion that Glenn is making,
9 which I think makes some sense, is there is some logic to
10 having a target, but that there should be some discretion in
11 how that target is being achieved. And here I'd make one
12 minor disagreement. I wouldn't change the relative values.
13 I would change the prices. You want the relative values to
14 still have a relationship to the underlying resource costs,
15 which is a whole elaborate process. But it may well be that
16 that's where you use some policy judgment about what are the
17 services that are most crucial and should not be reduced and
18 which ones is there a lot of information from various
19 sources that they are probably overpriced, or at the very
20 least, there's no difficulty getting a large volume of those
21 services produced on behalf of beneficiaries. So they could
22 be sort of selectively identified as the way to achieve

1 living within the target.

2 My own experience on the RUC and viewing the RUC's
3 work is that the fact that they actually live in a budget-
4 neutral world creates a discipline. When new services are
5 coming in every year, they can't simply say, oh, yeah, let's
6 value these regardless of the impact on the program because
7 they have a budget neutrality requirement that everything
8 else gets modified. So that creates some discipline. I
9 think there are some other problems that we're trying to
10 address around the accuracy of these services, but that's
11 one discipline that I think works well.

12 And so I do think, whether it was an overall
13 expenditure target or moving to what Kevin suggested as
14 maybe a few large categories, having some process to
15 actually pick and choose where to achieve the savings I
16 think could be much more palatable than simply across-the-
17 board cuts. And so that would be the point I'd make.

18 MR. HACKBARTH: Yeah, just two other ideas, and,
19 again, what I'm trying to do is get us thinking expansively
20 about how an opportunity might be used here. There are two
21 other ideas that occur to me. One is malpractice reform,
22 which at least some of us, I know, are concerned is not a

1 constructive force in terms of appropriate utilization of
2 Medicare resources. Another concern that I know some of us
3 have had about the ACO movement, if you will allow me that
4 term, is the risk that hospitals, by virtue of being the
5 organizations that have the capital and the management
6 infrastructure will sort of quickly come to dominate the ACO
7 world. And what about physician-based options? Well, an
8 idea that I picked up from Jeff Goldsmith is that there's
9 money in PPACA for development of co-ops. And, Scott, I
10 love co-ops, but I'm not sure that they're going to be a
11 rapid solution to any of our health care problems. That
12 money could be redirected to help support development of
13 physician IPAs that can start to have organizational
14 infrastructure to be leaders of or at least very active
15 participants in ACOs, and we won't just go into the
16 automatic hospital track.

17 Again, these are just ideas, but if we think about
18 broadly the problem of how do we change physician payment in
19 constructive ways, more effectively engage physicians in
20 controlling costs, and see that as the opportunity in SGR
21 repeal, I think maybe we could come up with a constructive
22 package.

1 You had a summary slide, Cristina, that has at
2 least some of these ideas. Do you want to put that up? The
3 GH slide I think it is. I'm not going to go through this
4 again, but it references some of the things that I just
5 listed.

6 Tom, I think we're starting on your side. Let's
7 do Round 1 clarifying questions before we leap into the
8 deeper discussion.

9 DR. DEAN: I'll pass [off microphone].

10 MR. HACKBARTH: Okay.

11 MS. UCCELLO: First of all, if it makes Cristina
12 feel any better, I use lots of hand gestures, and I have
13 knocked over my fair share of microphones.

14 A quick question. For the exemption policies,
15 would that mean higher reductions for non-ACO physicians?
16 Or is it just a whole separate -- we're only doing the
17 analysis or the target for the non-ACO folks?

18 MS. BOCCUTI: That's a very good methodological
19 question. You could ask that of other types of services,
20 too. So that has to do with predicting who's going to
21 participate and whether you start from zero or whether you
22 start from the current status of the SGR. But that's the

1 right question to ask if it were starting to be
2 operationalized.

3 DR. STUART: This builds on some of the same. One
4 of the problems with SGR is that when that first negative
5 update hit Congress, it really wasn't that difficult to
6 override it. The extra cost to the debt was relatively
7 modest, and it would be easy to say, well, we'll fix it next
8 year. And then it happened again, and then we had the
9 compounding.

10 So one of the problems was that it has gotten to
11 the point where it can't be -- you know, it just can't be
12 stuffed back into the bottle. And the question I raise is
13 when PPACA was enacted, Congress included a mechanism in the
14 Independent Payment Advisory Board that would apply
15 primarily -- well, at least originally -- to Part D and Part
16 C that would require that the board come up with some
17 mechanism or some policy by which an expenditure target
18 would be overcome, and then Congress would have to vote up
19 and down on this in terms of a fast-track legislation. So
20 I'm wondering whether staff has considered whatever the
21 alternative to SGR is. If there is some kind of a limit
22 that's imposed, have you examined what the implications

1 would be for Congress putting that kind of a constraint on
2 its own actions?

3 DR. MARK MILLER: Yeah, I mean, I guess the way
4 I'd start to try and answer this -- and, Cristina, you can
5 pick up here -- is that in the 2007 report, one of the
6 things that the Commission ended up talking about as one of
7 the ways you could go is just to keep an expenditure target
8 but not have it peculiar to a physician, have an expenditure
9 target across the entire program.

10 What we could do -- and we can move in that
11 direction if the Commission wants to think about things that
12 way. In that kind of a context, the kinds of things we
13 could play around with to give you a feel is if we have a
14 target for the entire program, whether it's using the stuff
15 that's in the legislation or a different target that you
16 discuss, we could simulate what impact it would have across
17 the entire program and make the assumption that the SGR is
18 not restraining the physician expenditures and then build
19 that into the impact. Is that the kind of thing that you're
20 asking?

21 DR. STUART: That's part of it, but I think having
22 a target and then whether that target is a real target or

1 something that can be easily overridden, and the IPAB
2 example is one where Congress itself said, well, we have
3 trouble keeping to targets, and so we'll write something in
4 the legislation that's going to make it harder for us to
5 override a target.

6 MS. HANSEN: On Slide 17, where we talked about
7 outlier policy for some of this, this is more on the profile
8 of the beneficiary side as to whether or not in looking at
9 outliers was they're a risk-adjusted consideration of the
10 beneficiary. In other words, there's some physicians who
11 practice and care for people who tend to cost a lot year
12 over year by their profile, not because of billing
13 practices.

14 MS. BLONJARZ: Yeah, and I think in the past the
15 Commission has supported risk-adjusted methods of resource
16 use. For the studies that we looked at in the paper, two of
17 them used risk adjustment and one didn't, but generally I
18 think that's something the Commission has supported.

19 DR. BERENSON: First, for Kate, could you just
20 clarify? When you're referring to per capita spending, are
21 you referring to the spending attributable to that practice
22 for a period of time a year, not the overall spending for

1 that beneficiary? Or are you?

2 MS. BLONIARZ: So what we -- it was very simple.

3 It was just the charges that that beneficiary incurred with
4 that physician.

5 DR. BERENSON: With that physician.

6 MS. BLONIARZ: Over the year.

7 DR. BERENSON: Okay. So you are dealing with the
8 number of episodes, you're not -- that's how you're trying
9 to sort of account for those physicians who have lots more
10 episodes is to look -- okay. But it is attributable to that
11 physician for the year as per capita. Okay.

12 MS. BLONIARZ: In that episode, that's right.

13 DR. BERENSON: And, Cristina, I just want to go
14 back to -- could you go to Slide 14? I'm picking up the
15 question that Cori asked, and I just want to understand it.
16 When you say exempt certain providers from current SGR
17 target or some substitute, how meaningful is that? If, in
18 fact, the ACO goes the route that MedPAC has recommended,
19 which is sort of risk taking on behalf -- to some extent,
20 not completely, the payments are sort of cash flow, and
21 ultimately the organization is functioning under a different
22 set of incentives and are almost -- I mean, what would be

1 the alternative? Let's say we had an expenditure target
2 that was a zero update and so they're exempt from that, what
3 then becomes what would be used for them? And does it
4 matter, I guess is my question.

5 MS. BOCCUTTI: Right, so it depends on how painful
6 the alternative -- you know, staying in the SGR is. Right?
7 So that's -- if it's used -- if this exemption policy, one
8 of the goals is to accelerate acceptance of delivery system
9 reforms, the theory would be that what remains, so those in
10 the regular fee schedule payment system wouldn't be as --
11 you wouldn't have the opportunities for bonus payments, and
12 you would essentially -- if a provider were weighing his or
13 her options would think that the delivery system reform
14 mechanism -- that's in this example ACOs or medical homes --
15 might get them the opportunity for higher payments if they
16 have good performance, which would not be available -- that
17 opportunity wouldn't even be there in the regular fee
18 schedule SGR

19 Of course, your question is whether you're looking
20 at an SGR mode of a 25-percent cut or an SGR mode of a
21 freeze. And I think that does affect participation.

22 MR. HACKBARTH: So I think I had the same question

1 as Bob. So if you're going to exempt an ACO, say, from SGR,
2 you've got to say, okay, they're not going to get the 25-
3 percent cut. What are they going to get? Because they're
4 going to be paid fee-for-service --

5 MS. BOCCUTTI: Well, it's not the ACO itself,
6 because that's going to have its own -- you know, that's
7 going to be determining its own payment mechanism. It's the
8 providers that are affiliated with -- the physicians and the
9 health --

10 MR. HACKBARTH: Correct. So I'm an ACO physician,
11 and by virtue of my participation in the ACO, I'm not
12 subject to the SGR cut. What do I get for an increase in my
13 fees? You have to create an alternative.

14 MS. BOCCUTTI: Right. We can discuss that, and I
15 would imagine that possibilities would be freeze plus. It
16 could also be determined by some of the ACO policies. Maybe
17 that ACO is developing incentives within its own structure.
18 Isn't that some of the idea there?

19 MR. HACKBARTH: Sure, sure. Is that what you were
20 getting at?

21 DR. BERENSON: Yeah, I was getting at that, and it
22 may well be that let's say we went to a type-of-service

1 expenditure target and imaging was reduced 3 percent or 5
2 percent. The ACO might not even mind that as a -- because
3 it's actually functioning, if, again, we went to a two-sided
4 or partial capitation approach. But it might. So we would
5 have to work through that issue of what the alternative
6 payment system would be to those individual components of
7 the ACO.

8 I guess my general sense is being able to go into
9 the ACO is the real attraction, but you are right, the more
10 Draconian the alternative is, the more likely organizations
11 will want to be off on their own, and I get that point. But
12 I think we have a mechanistic issue to determine what would
13 be the fee schedule.

14 MR. HACKBARTH: And in addition, to the extent
15 that the ACO's success or failure is based on, you know, are
16 they holding their costs below what's happening elsewhere,
17 the fact that they're getting fee increases puts them behind
18 the 8-ball compared to people outside who are having fee
19 cuts. And so you've got to think through what the
20 implications are for how you set the ACO target as well as
21 what they get in cash flow and fee payments.

22 Suffice it to say that, you know, it's easy to say

1 we're going to exempt ACO, but there are some fairly
2 complicated design issues that need to be worked through.

3 MR. KUHN: A couple different questions here.

4 One, I'd go back to the SGR expenditure target, and that can
5 change for three reasons, as I recall. One is population,
6 one is changes in physician practice expense, and the third
7 is change in law and regulation. Two parts to that last
8 one.

9 When will we know the changes particularly in law
10 that as part of PPACA will impact the target? Will that be
11 something that will get from CMS in that kind of annual
12 letter that they send us? And presumably they'll be coming
13 in the next month or two. Is that where we'll see what the
14 CMS Office of the Actuary projects will be the change as a
15 result of PPACA changes on the target?

16 MS. BOCCUTTI: Yes, we usually get that in the
17 springtime, so upcoming, and they do delineate on all the
18 factors that affect the SGR formula and predicted update.

19 MR. KUHN: And on that projection, the one -- I
20 keep getting different stories on this, and even after my
21 time at CMS, I have to admit I'm still not clear on this
22 one. But, again, law and regulation, but there are national

1 coverage determinations, which are neither. They're neither
2 law nor regulation. They're kind of a creation within CMS.
3 How does OACT -- do we know OACT scores those in terms of
4 the target?

5 MS. BOCCUTI: Kevin, in your experience?

6 [Laughter.]

7 DR. MARK MILLER: I actually remember us having a
8 conversation with them.

9 MS. BOCCUTI: You and me?

10 DR. MARK MILLER: No, Kevin and I.

11 DR. HAYES: Right

12 DR. MARK MILLER: But for the life of me, I can't
13 dredge it up.

14 DR. HAYES: Right. What I recall of that
15 conversation, lo these many years ago, was that a lot of
16 times the national coverage decisions are institutionalizing
17 local coverage decisions, and that the spending associated
18 with these coverage decisions is already pretty well built
19 into the base. It just sort of arrives there organically.
20 And so there is no provision for coverage decisions in that
21 law and regulations factor; rather, the law and regulations
22 factor tends to be things like new benefits that are in law,

1 floors on the GPCI, and that kind of thing.

2 MR. HACKBARTH: Clarifying questions?

3 MR. KUHN: Yeah, just one more, if I could. As we
4 think about it and getting into this, you know, part of the
5 overall discussion continues to be the refinements of the
6 RVUs out there for both practice expense as well as work.
7 And as we all know, the work of the RUC has begun to evolve
8 and change over time so that this whole notion of the five-
9 year review doesn't really exist anymore; it's more of an
10 iterative process, and they're keeping up on a regular
11 basis. And they seem to be working, from as near as I can
12 tell, real good on the work side, but I'm curious where we
13 think we're going to see any adjustments on the practice
14 expense side. Will that continue to kind of follow a five-
15 year review kind of model? Or was that something that CMS
16 will probably take up more aggressively in regulatory
17 action?

18 DR. HAYES: The rolling review process is picking
19 up practice expense changes, too. The practice expense data
20 are improved along the way. The effects of those changes
21 then are picked up in the budget neutrality adjustment that
22 happens within CMS' practice expense methodology. So we

1 wouldn't see any separate identification of those things,
2 those effects, those changes that we could point to and say,
3 oh, well, that's what the effect of it was. But it is
4 getting picked up in that methodology. There's budget
5 neutrality mechanisms built right into the methodology
6 itself.

7 DR. KANE: Yeah, so one question I had is in the
8 early years the SGR was above the spending, and so there's
9 really -- aren't there kind of two things going on? One is
10 the spending is accelerating, but the other is that the
11 economy is decelerating. And I guess one question I have is
12 if you just took our historic acceleration rates for Part B
13 spending and then assume the economy kind of grew faster or
14 at least at the rate that it grew in the first three or four
15 years there, you know, then what would we be left with? How
16 much excess spend -- I mean, is there a way to sort of say,
17 well, let's take -- some of this is because the economy
18 crashed, and that's not fair, but, you know -- and some of
19 it's because you guys, you know, maybe spent more than you
20 should have because your rates didn't grow.

21 I guess I don't have any sense of how much of the
22 total deficit we're incurring now is related to the fact

1 that GDP hasn't been growing relative to historic levels as
2 opposed to the fact that spending has exceeded GDP in some
3 outrageous -- does that make sense?

4 MR. HACKBARTH: You're certainly right that it's
5 the combination of the two factors that determines what the
6 gap is.

7 DR. KANE: Right.

8 MR. HACKBARTH: It's both the rate of spending and
9 how fast GDP's growing.

10 DR. KANE: And this is just a question, not to
11 necessarily solve anything, but I'm just trying to get a
12 sense of equity of how you want to sell this idea of what
13 really should fall on the backs of the docs and what might
14 fall on the backs of something else.

15 MR. HACKBARTH: Long before the recent recession,
16 the score was huge for repealing SGR, and it's a rolling
17 average used on the GDP. Is it three years?

18 DR. HAYES: Ten [off microphone].

19 MR. HACKBARTH: No, ten years. That's right.
20 They changed it. So the effect of the recent recession on
21 this is muted because of the ten-year moving average.

22 DR. KANE: But if you left -- I mean, we really

1 have had one of the worst recessions in the history of the
2 Nation, and that's built into that.

3 DR. MARK MILLER: That's just in the last year
4 [off microphone].

5 DR. KANE: So that's not the biggest piece.

6 DR. MARK MILLER: The volume is.

7 DR. KANE: Yeah, I'm sure it doesn't erase it.
8 I'm just wondering if we assumed a more normal growth in
9 GDP, what would the ultimate deficit be that we -- relative
10 to -- you know, is it 10 percent, 2 percent?

11 MR. HACKBARTH: Yeah, okay.

12 MR. BUTLER: So, Glenn, I just want to make sure I
13 understand your framework, and so let me restate it in my
14 own words. One could say that a month ago we voted for a 1-
15 percent increase for physicians because we felt that that
16 was required for access and, you know, being a good,
17 efficient provider, which doesn't exactly close the hole.

18 Then you said normally we would have a lot of
19 offsets to that. But, in fact, you already stole them all
20 and used them for the health care reform and counted them as
21 offsets already for the most part -- ACOs, bundling, and so
22 forth.

1 So if we're going to contribute more to closing
2 the gap, so to speak, or fixing this, one could say we'll go
3 back to those ideas and accelerate them and put them on
4 steroids or whatever and say doom and doom faster. Another
5 would be to say let's come up with some additional ones
6 between now and next fall, including the topic we're going
7 to talk about next. And then a third may be your payment
8 reform, things that may not have money necessarily with them
9 but, you know, kind of resets the way you look at it. Is
10 that kind of what -- so when I make my comments, that's kind
11 of how I heard you approaching it.

12 MR. HACKBARTH: Yeah.

13 MR. BUTLER: Okay.

14 DR. BERENSON: Could I just weigh in? But the
15 major offsets were in Medicare Advantage reductions and in
16 hospital --

17 MR. BUTLER: Updates.

18 DR. BERENSON: -- updates, not in sort of guesses
19 about what ACOs are going to do.

20 MR. BUTLER: Which is a reason why you could go
21 back and say could you somehow get a little more teeth,
22 double-sided, whatever it is to kind of accelerate --

1 DR. BERENSON: I see.

2 MR. BUTLER: -- scorable offsets by kind following
3 our philosophy of bundling and getting utilization out of
4 the system.

5 MR. GEORGE MILLER: Yeah, just a quick
6 clarification on the outlier alternative, Slide 16. Do we
7 know where these physicians are practicing? For example,
8 can we stratify them working at FQHCs or rural areas or
9 urban areas? Do we have a feel for that? Or is this just
10 across the board?

11 MS. BLONJARZ: I would clarify first that most of
12 the studies use 100 percent data from six MSAs.

13 MR. GEORGE MILLER: Okay, sure.

14 MS. BLONJARZ: We could look at where they're
15 practicing, but that would be drilling down pretty far.

16 MR. GEORGE MILLER: Okay. Thank you.

17 DR. BORMAN: This whole topic sort of goes to
18 prove that it takes 50 acres of ocean to turn a battleship,
19 and I think in your nice reprising of the history, I'd like
20 to hear from you and our expert folks who are truly here.
21 Just how much of this at its inception was an experiment and
22 a prediction? I mean, this has gone so fundamentally

1 poorly, and it exemplifies that, albeit we make big
2 decisions about lots of money with relatively limited data,
3 and a lot of the time it works, but this seems to me one of
4 the times that exemplifies how catastrophically it can fail.

5 So in order to avoid repeating that mistake, as I
6 go back, what really convinced us that this would work? Was
7 there some thought process or thinking that we don't want to
8 repeat in figuring out the solution that you recall
9 historically or you analytically can identify?

10 MR. HACKBARTH: Well, to be frank, I came to
11 MedPAC in 2000, and so it was very shortly after I arrived
12 that we recommended repeal because we thought the system was
13 fundamentally flawed and would not achieve its goals. So
14 I'm not the right person to say, you know, who thought this
15 would work and why. I don't know, Cristina, Kevin, whether
16 you have insight on that that I don't have.

17 MS. BOCCUTTI: I was just going to say the
18 rationale -- Kevin, maybe you could mention about going from
19 VPS to SGR, and maybe that is just one rationale that was
20 out there, because if the fee schedule started with an
21 expenditure target but it was under VPS and then moved to
22 SGR, maybe Kevin studied this.

1 [Laughter.]

2 DR. MARK MILLER: Can I just ask one thing before
3 you -- were you asking what the logic was that built it? I
4 didn't think you were. I think what she was --

5 DR. BORMAN: Go ahead, Mark [off microphone].

6 DR. MARK MILLER: I think what you were asking was
7 this was put in place. We've now arrived at a point in our
8 discussions where, you know, people are convinced that it
9 doesn't work. What are the key signals that have brought us
10 to that point so that we don't repeat them?

11 DR. BORMAN: Yeah [off microphone].

12 DR. MARK MILLER: Okay. I don't know.

13 [Laughter.]

14 DR. MARK MILLER: My job is just to be clear on
15 the question. But, I mean, I think --

16 MR. HACKBARTH: The question is: What do we think
17 the design flaws were in SGR so we don't repeat them?

18 DR. BORMAN: What got us to the -- I understand
19 the part that relating it in some way to the average worker
20 productivity, the productivity of the economy as a whole,
21 whatever. I understand all that in terms of linking the fee
22 schedule to that as some measure of making sure that

1 physician payment is reality grounded and all those kinds of
2 things. There just had to be something other than the fact
3 that the GDP hasn't grown. You know, we were wrong. The
4 economics didn't work out in the trend pattern that perhaps
5 we thought there would be.

6 MR. HACKBARTH: Yeah.

7 DR. BORMAN: And there were all these perverse
8 incentives that perhaps we didn't envision that have played
9 out. Are there any other sort of assumptions or thinking
10 that we should look at to avoid? And it may be an
11 unanswerable question, Glenn, and I don't want to belabor
12 this. I'm just bothered by we've got such a very large
13 failure now that it's going to be so hard to meaningfully
14 correct, and to correct in a fair way in a very difficult
15 environment of being a bankrupt nation. You know, I'm with
16 you, and I worry about that a lot.

17 MR. HACKBARTH: Yeah.

18 DR. BORMAN: So I'm just trying to -- is there
19 something we can tease out that will help us inform this
20 conversation better? And is that something we need to think
21 about maybe going forward?

22 MR. HACKBARTH: So let me try this, and this may

1 not be 100 percent based on facts. Some of it is
2 speculation on my part. And this happened in the 1990s,
3 first with the VPS system, which was '91, '92, Kevin,
4 thereabouts. And then it was modified to SGR in '97. This
5 was the year of managed care, and, you know, a common sort
6 of structure among IPA-type HMOs was to say we're going to
7 pay you fee-for-service, but as a plan we're subject to some
8 total cost constraint, and so we've got to hit that target.
9 Your share of the target is this. If you miss your share of
10 the target, we've got to take it out of your fees. Ad
11 IPA/HMOs had lots of variations in how they tried to do
12 that, but that was sort of a common thing that happened in a
13 lot of different places in the '90s. And so this was an
14 effort to sort of apply in some sense similar thinking to
15 Medicare.

16 Well, in point of fact, many IPAs blew up for the
17 very reason that SGR blew up. You know, you can say, oh,
18 we're going to pay you fee-for-service and there's an
19 aggregate constraint. That doesn't alter the incentives of
20 the individual practicing physician. They still have fee-
21 for-service incentives. And, in fact, if they're worried
22 about a cut coming because you missed the target, oh, even

1 do more. You increase your volume so that after the cut
2 comes, your damage is minimal. And there were IPAs all over
3 the country that -- well, that structure blew up, and they
4 tired different physician payment formulas.

5 Well, we've had the exact same problems in
6 Medicare. We've got an aggregate target, but the incentives
7 for individual physicians are not tied to the target, and
8 you get not just tension, you get a fundamental breakdown of
9 the system.

10 And so I think, you know, the enduring lesson,
11 which we've talked about often over the years here, is it's
12 not just enough to establish a cap on something. You've got
13 to figure out how to more fundamentally rewire the system to
14 change incentives at the level of decisionmakers, whether
15 they be physicians or hospitals or other providers.

16 Does that help?

17 DR. BERENSON: Could I?

18 MR. HACKBARTH: Go ahead.

19 DR. BERENSON: I've done a little bit of
20 historical reading on this topic, and the initial thought
21 around an expenditure target actually I think was informed
22 somewhat by the German health care system, and I know GAO

1 had a whole report about their expenditure target mechanism.
2 I still remember an '89 PPRC report which identified the
3 problem with an overall expenditure target, but then had
4 this optimistic statement saying that this will hopefully
5 encourage physician specialty societies to develop clinical
6 practice guidelines and be able to inform practicing
7 physicians about how to live within an expenditure target,
8 because they would no longer be doing unnecessary things.
9 There's some reason that this worked somewhere, and there's
10 some logic of what they anticipated might happen.

11 So the first years of the VPS, nothing was blowing
12 up in particular. Volume wasn't going through the roof.
13 There were three targets in those days, and, in fact,
14 surgery got a very nice increase because volume was not
15 exploding in surgery, and so I think the BBA was really sort
16 of -- we can even do this better. It hasn't really failed.
17 It's actually been a partial success, with some problems.
18 And even in the first couple of years of the SGR, it hadn't
19 blown up even though MedPAC was beginning to see the problem
20 with it.

21 So I do think there was obviously the environment
22 of managed care going on at the time, and I think it has

1 some spillover effect also about not generating lots of
2 volume increases. I think there's probably a spillover
3 effect when the managed care backlash occurred, and I think
4 that also probably let the restraints off, which also then
5 got translated in Medicare as well. This is my speculation.
6 But I can point to that '89 PPRC report which had a whole
7 chapter on the logic of having an expenditure target,
8 acknowledged the problem but thought that the physician
9 community would address it somehow.

10 DR. BORMAN: Thanks [off microphone].

11 MR. HACKBARTH: Okay, so that was Round 1. We
12 need to, as quickly and effectively as possible, go through
13 Round 2. Tom, will you be an exemplar of concise comment?

14 DR. DEAN: I will try. I think I can. I
15 appreciate the attempts to try and possibly make this flawed
16 structure more attractive, but I think we get back to the
17 point that it's just a fundamentally flawed structure, and I
18 don't see any way to fix it.

19 I think the proper approach is to repeal it. If
20 we can use that as a tool to bring about some other desired
21 changes, fine. But as hard -- and like I say, I appreciate
22 the work you folks have done, but I just don't think there's

1 any way to fix this. The fundamentally flawed structure for
2 the very reason, Glenn, that you talked about, it doesn't
3 give the incentive to the individual physician to change
4 behavior. And I think we have far more promising and
5 efficient ways to do that, and we should -- this is a
6 failure, we should acknowledge it, and move on.

7 MS. UCCELLO: I want to react somehow to that, but
8 I don't -- I'm not as kind of pessimistic. I actually
9 started off, you know, several months ago when we started
10 these -- or at least in my term started these, I went from
11 almost having negative views of all of the options to almost
12 having positive views of all of them and focusing on, well,
13 they can at least do something, they're at least better than
14 what we have now.

15 Two quick points. Thinking about the idea of
16 trying to properly incent the individual physicians would
17 lead to this outlier policy and potentially this exemption
18 policy. But I think those are just really small kind of
19 things that aren't going to get us very far.

20 The more I think about it, the more I like the
21 different targets by the type of service, and one part of
22 that or something that was said is an advantage of that is

1 that it can help kind of partly adjust for price
2 inaccuracies. And I was kind of bothered by that, thinking,
3 well, if there are price accuracy problems shouldn't we just
4 fix the prices somehow? So I think instead tying it to the
5 way that Glenn said of, you know, having a different SGR
6 policy and tying that to a reset of fees would be the way to
7 do that, and I think that that would be appropriate.

8 MR. HACKBARTH: Let me just contrast the two
9 comments. Tom is much more in "repeal, wipe the slate
10 clean, start over." What I hear you saying is that you want
11 to at least explore further some of the "well, let's fix it
12 without scrapping it" sort of options.

13 MR. ARMSTRONG: Yeah, I guess I'm kind of in the
14 middle. First, I just want to say I think we're doing a
15 better and better job of describing the problem, and it is
16 sobering. I think in many ways this epitomizes so many of
17 the other issues that we're dealing with in a system that's
18 so built around these silos. And it reinforces or pays for
19 things that really aren't as important as, you know, better
20 health and lower trends and so forth.

21 It's also frustrating and sobering because we know
22 there are hundreds of billions of dollars worth of trim that

1 need to be taken out of this at the same time. And so it
2 leads me to -- I'm not sure that there are constructs laid
3 out in your alternatives that I like better or worse, but to
4 the degree we look at what do we want providers to be paying
5 attention to, and we've got ideas that have been developed
6 through ACOs or medical homes or other ways of bundling
7 payments to promote different results and hook this
8 resolution into those ideas, I think per your advice. I
9 like going forward with it. That seems like a constructive
10 way of leveraging the pressure we're all feeling around this
11 to try to move this agenda forward.

12 MS. BEHROOZI: I share Tom's sentiments, but I
13 don't know that just repealing it -- forget political
14 realities -- produces anything for having had it in place
15 all this time. I guess that we do sort of have to
16 acknowledge that it's not going -- the hole's not going to
17 be filled, certainly not in one fell swoop by, you know, any
18 recommendation we make or an act of Congress. And I am
19 concerned that it's dealt with in this crisis-oriented,
20 year-by-year fashion where you can't do any of the more
21 interesting things. So I'm not sure where that leaves me
22 either.

1 I think that we absolutely should be pushing
2 forward the other alternatives, not even necessarily in the
3 SGR context, though, kind of, you know? So that's why I so
4 agree with Tom's sentiments because it's almost irrelevant,
5 except that it keeps creating all these crises. What is
6 relevant is trying to find the right kind of payment policy,
7 and, you know, I find some appeal, Glenn, to what you say
8 about maybe using it as a bit of a stick to try to encourage
9 more support for better payment policy, not necessarily as
10 alternatives to the SGR but, you know, a better
11 comprehensive payment policy.

12 DR. STUART: Repeal. Failing, repeal. As far as
13 tying it to the other, I think this is essentially a
14 political call in terms of whether these things that we're
15 in favor of in any event could be pushed forward. And if
16 there was an assumption that that would work, then I'd be in
17 favor of that.

18 MS. HANSEN: Yeah, I think it has to be consider
19 "repeal but for." I think what Scott was saying earlier
20 about having the product that we're trying to achieve -- and
21 that is, for example, if there's unintended iatrogenic care
22 -- in other words, a lot of this stuff is because of

1 duplicative things, the fact that we're seeing multiple
2 specialties that end up crashing into one another with the
3 beneficiary having a quality outcome that's not good, then
4 we need to hook in a performance-based outcome of what
5 happens to the beneficiary when there are known clinical
6 guidelines. There are many places where it's not known, but
7 whether it's diabetes, whether it's congestive heart
8 failure, whether it's arthritis, things need to be practiced
9 with evidence from an earlier RAND study about things that
10 aren't necessarily done that should be done. So something
11 has to be demanded if we're going to let go of this so that
12 the outcome on the part of the beneficiary is better off.
13 In other words, we may not use as much services then in
14 acute care because people's steady state is maintained. So
15 that's where the hook is if we are going to repeal it.

16 DR. BERENSON: Well, I agree with your sentiments
17 and the others around the table that the SGR has become a
18 real problem at this point. It's not just a legislative
19 issue. It really affects the trust that physicians have in
20 working with Medicare, and more specifically it is very hard
21 to get anybody's attention to correct the distortions in the
22 fee schedule as long as this thing is hanging over

1 everybody's head.

2 I am attracted -- as Bruce said, if we can figure
3 out a package that works politically and offers something
4 up, that sounds attractive to me rather than simply telling
5 the Congress to bite the bullet and pay for the SGR to
6 disappear.

7 I think in any of our work we should not use the
8 term "SGR" if we're talking about alternatives. The SGR is
9 a specific thing which, I mean, in a sense you can't use the
10 word "capitation" anymore. Even though most of us know what
11 capitation means, you have to call it "global payment." I
12 understand why one has to do that. We are not talking about
13 a modified SGR. We, I think, need to talk about eliminating
14 the SGR, but then maybe having a new process, reconstruct
15 volume performance standard or something else. But it will
16 get misinterpreted just like I wasn't sure what you meant in
17 terms of exempting ACOs from the SGR. Is that the old SGR?
18 The new SGR? Whatever we're going to describe, we got to
19 use some different terminology for it.

20 I think most of the action -- I'm with Cori --
21 should be correcting distortions, but there's 6,000 codes,
22 and we've got a lot of impediments to getting there. I

1 would much rather go right to the overpriced services and
2 reduce those prices. But I see a type of service approach
3 as a potential fallback to discipline that process. And
4 what's real important is that it wouldn't have some of the
5 same characteristics that the current SGR system has, such
6 as the cumulative nature. So when you get to 25 percent,
7 it's a trigger that can't be pulled. If it's a potential 2-
8 percent or 4-percent reduction in something that has a basis
9 to it, that trigger can be pulled. And so I think doing it
10 with some political reality about what is achievable I think
11 would be a very different approach to what's being done
12 right now.

13 And I guess my final point, two final points, is I
14 like the outlier approach, but it seems to me that's not
15 going to raise much money, and it seems sort of it's part of
16 the whole value index work. I mean, CMS is supposed to be
17 able to measure the value of a physician. I'm quite
18 skeptical that there is a numerator there that we're going
19 to measure the quality. If we're good enough to be able to
20 identify outliers on resource use, that's a terrific thing,
21 and I will do the work. Whether it's best to put it into
22 this discussion or whether it's part of the ongoing

1 discussion about how we sort of move towards a value index,
2 I'm not sure. But since it doesn't raise a lot of money,
3 I'm not sure it belongs here if we do it right.

4 And the final thing is in modeling any
5 alternatives to the current SGR, whatever we call it, I
6 think we need some that don't hook off GDP. I see some
7 logic in macro budget discussions of deciding how much can
8 society spend on Medicare, having a relationship to GDP
9 makes some sense. When we're talking about a sector within
10 Medicare, I don't see the logic of tying that to GDP. So
11 I'd be looking at some other things like MEI or zero
12 updates. I mean, I wouldn't just do GDP, I guess, because
13 that's what they did in 1997. I'd be a little more -- I'd
14 be thinking of some other hooks to base an update on other
15 than GDP. That can be part of the analysis. But I really
16 think it's a flawed concept to update physician payment
17 based on GDP.

18 MR. KUHN: As I get to travel around Missouri and
19 a lot of the Midwest, particularly since PPACA was passed,
20 and talk to a lot of hospital boards, hospital leadership
21 teams, a lot of physician groups across the Midwest, I can
22 tell you that there's probably nothing more destructive in

1 terms of the opinions of where we're going in health care
2 than this albatross that just hangs across all our heads.
3 And so this discussion is very helpful that we're continuing
4 to move forward as we look at these issues.

5 Just two thoughts here as we go forward. One, I
6 think the menu of options of the various items out there,
7 whether it's the cumulative aspect, the type of service, the
8 exemption altogether, or the outlier exemption, all those
9 are interesting, and I'd like to continue those
10 conversations on those. But one thing Glenn said and one
11 additional thing is that the idea of linkage to other kinds
12 of reforms as part of this is absolutely critical. I mean,
13 this is, you know, a chance to really make some of those
14 changes that are probably long overdue and need to be made.

15 But the other thing is what we can't lose sight of
16 this whole conversation is whatever we decide to do here or
17 recommendations that we ultimately put forward, we still
18 have the fundamental issue on the physician fee side, just
19 like we have in all parts of Medicare, is volume and
20 intensity. And whatever we put in place, what kinds of
21 incentives are they going to put in place to deal with
22 volume and intensity? Because that's the route that SGR was

1 put in place to deal with, because on all the other
2 prospective payment systems you get a predetermined amount
3 for a bundle of services. They had utilization control
4 there. You didn't have it with a fee schedule. And so what
5 ultimately is going to be the utilization control here on a
6 go-forward basis, one that we hope will work effectively?

7 So to be continued, I guess.

8 DR. CASTELLANOS: Most of what I was going to say
9 has already been said. Can we get to number 21? I think
10 that was it. There's a couple of good points here.

11 We have got to consider the budgetary issues. I
12 mean, sure, I want to get rid of the SGR because it hasn't
13 worked. It really hasn't. But, again, we have a
14 significant issue with the budget, and we really need to
15 look at and find out how we can do something that really
16 doesn't upset the problems that we're seeing in our nation
17 today of being further in debt and further in debt.

18 As far as the policy goes, you know, I'm very
19 proud of a lot of the work that MedPAC has done. We really
20 want to reward efficiency. We want to help reward quality.
21 We want to improve outcomes. And the only way we're going
22 to do that is to get the individual physician responsible

1 for what he or she does. And that's what the SGR does. So
2 whatever system we go to, whether it's ACO concept, whether
3 physicians are responsible for quality and outcomes and at-
4 risk, or whether it's bundling, or whether it's a Geisinger
5 model where you get a salary plus you get paid as a bonus
6 for outcomes and quality, we need to go somewhere where we
7 stress some of the things that we as MedPAC have always
8 cherished.

9 I can't tell you -- and Herb mentioned it -- the
10 pervasiveness of the destruction of what the SGR does in the
11 medical community. I've never seen it so much, and we saw
12 it quite a bit in December. And, fortunately, we have a
13 reprieve for a year. So we really need to do something this
14 year. We really need to do something.

15 One-third of the physicians in the United States
16 are over 55, and with the economy coming back and the more
17 hindrance you're putting on the physician with HIT, MR,
18 workforce issues, penalties for not doing e-prescription,
19 penalties for not doing PQRI, you're going to have a lot of
20 the physicians saying, you know, maybe it's not worth it
21 anymore. We can't afford that because we have a real
22 workforce problem.

1 So I kind of agree that we should not use the word
2 "SGR." We have to use something else, and I'm not sure what
3 you guys have to say, but we need to hide that under the
4 sheets.

5 Now, as a physician -- I can't speak for the
6 physician group, but as a physician, I'm more than willing
7 to consider other options, whether it's a package like Bruce
8 or Bob mentioned, but I'm more than willing to do that. And
9 I think realistically the physician community wants to solve
10 this problem just as much as we want to solve the problem.

11 Now, we talked about volume restraints. I'm just
12 mentioning it. If you look at the volume that's happened
13 over the last couple years, there has been a decrease in the
14 growth of volume. I'm really not sure why, but I think a
15 lot of it can be from the Deficit Reduction Act by cutting
16 back reimbursements. And I know you've mentioned that, too.
17 When we cut back and pay appropriately, maybe we take that
18 impetus away from this fee-for-service.

19 The last point I really want to make is fee-for-
20 service. You know, we had to get away from that model
21 somehow. I agree with Bob, we need to consider and continue
22 some of the RUC's policies where we look at the cost of

1 providing the different treatments. But don't use it as a
2 payment model or a pricing mechanism.

3 I agree about the defensive medicine and tort
4 reform. I think that would be a significant improvement.

5 We just need to put some key signals out there
6 where we recognize there's a problem with the SGR, we want
7 to solve it, and that it's important not just for health
8 policy people but for the physician community and sit
9 together and see if we can work out something that's
10 workable for society and our beneficiaries.

11 DR. KANE: Yeah, well, this is the topic that
12 makes me want to, you know, retire the meeting early, but
13 SGR, it seems to me that it's a volume problem that we have
14 that we're trying to solve with a fee solution. That just
15 doesn't even get near what you're trying to get to. And
16 when you look at that figure that shows you where we went
17 off, in '03, '04, '05, and if you look at what services were
18 going through the roof growth-wise back then and a volume
19 way, it was imaging, it was tests, and it was those other
20 procedure type things.

21 And so I guess I have sort of a volume solution.
22 It's a little bit Third World-y, because I know what they do

1 in the Third World when they have a budget. They just stop
2 paying for the services at the end of the month until they
3 get a new budget. This is kind of on that idea but a little
4 bit more sophisticated, perhaps. But it seems to me we need
5 a volume solution that -- and I frankly think tort reform
6 would help that volume solution at some level. I don't know
7 how much defensive medicine is contributing to all the tests
8 and imaging. But, you know, perhaps that could be combined,
9 some type of tort reform that says, okay, because we're
10 passing it, we are expecting volume to drop by blah, blah,
11 blah. And for each health resource area, you have an
12 imagine and a testing and an other procedure limit. And
13 each month you're tracking the claims up to that limit, and
14 when you hit it you stop paying. You might create a little
15 withhold out of the amount you think you owe. You know,
16 talk about funny accounting. You could also do that. You
17 can call it a payable maybe, and you just wait and see if
18 the volume goes below those targets for that HRR. You're
19 kind of keeping it at least within the referral regions that
20 people practice, have common practice patterns, and you may
21 have a lower limit, by the way, in high-volume areas and a
22 higher limit in low. And you just create -- over time the

1 signal starts coming through monthly, that, you know, you're
2 not going to get paid for that because you hit your target.

3 And I'm guessing that and getting rid a lot of the
4 -- especially if you combine it with tort reform -- people
5 will get that message after a while that I should be more
6 judicious in the use of tests, imaging, and other
7 procedures, and so I can stop having this withhold. And the
8 withhold stays until they go down below the volume level or
9 are at the volume level you want. And if they go below it,
10 they get it paid back. If they don't, it gets applied
11 against what is owed on the SGR, which is going to be called
12 something else, whatever you want to call it.

13 But I just think you have to do -- I think I'm
14 agreeing ultimately. You need multiple things. It can't
15 just be one thing to get at it. It's really got to be
16 targeted at volume, not rates. I agree rates need to be
17 fixed, but I think that's a whole other -- keeping up with
18 the RBRVS and keeping it modern is just, you know, a very
19 hard task. But for a quicker task, I think we just go for
20 the volume. And we know where the excess was, and we just
21 start saying those are the things, you know, that we're
22 going to -- you're going to run out of being paid for those

1 on some periodic basis, quarterly maybe, that's meaningful,
2 that people say, yeah, I just ran out.

3 Again, they do this in the Third World. They do
4 this in a lot of county-run hospitals. You're out of money;
5 we're not paying for that. And people pretty quickly learn
6 how to hit the right level of volume and service to not run
7 out of money.

8 So, anyway, that's my Third World solution, but,
9 again, I think we have to think about this as how do we fix
10 the volume and stop messing with -- the rates is not the
11 issue. It's the volume. The whole payment mechanism, fee-
12 for-service, is the problem. But, you know, fiddling around
13 with lowering everybody's rates does not solve the volume
14 problem. It makes it worse, I think. I just think people
15 should just not be paid for the whole thing if the volume
16 exceeds the targets, and the target should be at a level
17 that's local enough that people can sort of be responsible
18 for it, can be given feedback on it, but to take collective
19 responsibility for it. And then you can obviously opt out
20 once you get into a risk-bearing ACO or something like that.

21 So that's my -- you know, I've been listening to
22 this for a long, long time, and we did that report to

1 Congress, and it wasn't enough for them, and they wanted the
2 solution. So, you know, come up with something totally
3 arbitrary, but that links in some really good things. And
4 the arbitrariness will go away once we get these really good
5 things underway.

6 MR. BUTLER: So in managed care, I think
7 physicians demonstrated a lot of leadership in the early
8 days about being leaders of the reform of the system.
9 Ultimately, Glenn, you'd say they were the leaders of the
10 backlash maybe to some extent as well. So in the last year,
11 I've seen health systems and insurers, maybe out of fear,
12 maybe out of other reasons, suddenly think, I've got a value
13 proposition out here that is significantly different. And
14 they're working hard on it, insurers and health systems,
15 while physicians are kind of on the sidelines wrapped up in
16 SGR. I just don't see the leadership.

17 So I agree with Bob and with what the rest of you
18 are saying. Really futzing around with SGR as we know it is
19 just a fruitless exercise. But I really like your idea of
20 even a broader concept of the payment reform for physicians,
21 somehow using this as the catalyst to get them not just not
22 angry but in a leadership role, because we're going to need

1 them. There's not an easy way to solve the budget, but I
2 think, you know, Deficit Reduction Commission, IPAB, all
3 these things are going to kind of trump this SGR question
4 pretty quickly anyway. So let's use the opportunity to get
5 the physicians back at the table in leadership roles, and so
6 I like that theme.

7 DR. BAICKER: I'll try not to retread ground that
8 has been very carefully covered. This is probably overly
9 simplistic, but I understand the goal of the original SGR to
10 be twofold:

11 One, to have a global budget guarantee. We don't
12 want to spend more than this, so if quantity goes up, price
13 is going down, because here's our budget.

14 But then another twin goal of trying to instill in
15 the people who are making those decisions the right
16 incentives to not exceed that.

17 It seems like it failed on both dimensions for
18 different reasons. The reason it failed on promoting higher
19 value use was that the incentives weren't tied to any
20 individual physician. The extra test I order has no
21 incremental effect on my future payment, it's so small. So
22 it doesn't create any incentive for me as a physician.

1 And then on the other side, my understanding of
2 requiring making back the gap from previous years was to
3 give the incentive some real bite. But it was too much bite
4 because then no one could ever do it. And once you get in
5 this hole, it's politically untenable to try to make back
6 the whole thing. So then once that part is not binding,
7 you've lost any real cudgel to make the thing move.

8 So I really liked the ideas of bringing the
9 incentives down to the physician level, and, you know, any
10 step in that direction seems promising to me, whether it's
11 type of service or type of specialty or area-specific, and
12 the smaller the area the better; even better, at the
13 individual physician level so that individuals can see some
14 consequences from those actions. And the challenge there
15 seems like balancing insurance versus incentives. It comes
16 up all over the place when we're talking about patient
17 incentives or how insurers are operating in that. We don't
18 want individual physicians to bear the risk of getting a bad
19 draw of expensive, unhealthy patients, and we certainly
20 don't want physicians to face a disincentive to persistently
21 enroll high-cost patients. I could imagine that some of the
22 people who are in the persistently high costs are people who

1 would declare that they're specializing in treating the
2 hardest-to-treat patients, and, of course, it's high every
3 year because every year I've got the sickest.

4 We've made this joke before, but it seems like the
5 reverse Lake Wobegon effect that every physician's panel is
6 sicker than average. But I would think with sufficient risk
7 adjusters, you could try to combat that and create an
8 incentive that gives physicians some stake in managing that
9 volume while at the same time not asking them to bear the
10 risk that the program should be bearing. We should be
11 insuring them against expensive patients. It shouldn't be
12 the individual's responsibility. And that's a very
13 difficult formula to write down.

14 Then you, I would hope, could broaden the
15 discussion of the global budget constraint issue beyond the
16 physician silos. We've talked about why would you want to
17 set your global program budget just on the backs of one
18 segment of care. So thinking about that second -- divorcing
19 those two goals and thinking about how can we get Medicare
20 spending under control more broadly, well, that may involve
21 some sort of global budget that goes across silos. That's
22 one discussion. How can we line of physician incentives?

1 Let's do that in a way that balances incentives and
2 insurance, et cetera. Those may not go together the way
3 they are supposed to now, but clearly fail on both
4 dimensions.

5 MR. GEORGE MILLER: Yes, we've a very rich
6 discussion. I'll try to be brief. And some wonderful ideas
7 and comments have been said, and I agree with a great deal
8 of what has been said already.

9 I don't know what to call it since Bob said we
10 can't say that, so I'm going to say "this new thing." I
11 think the new thing certainly needs to have physician
12 leadership, as was just said. And I think as leaders we
13 need to pick a date out in the future saying that the old
14 thing will go away, the new thing will start at some point
15 in the future, and these are the goals of that new thing
16 that we will work to. But it certainly has to be all-
17 inclusive globally. We need to go down to the physician
18 level for quality and outcomes and then tie the
19 beneficiaries in with that also, because the physician says
20 you need to stop smoking, and if that beneficiary doesn't
21 stop smoking, then maybe they should pay more, and to link
22 everything together in the system.

1 I certainly like what you said about medical
2 malpractice reform. I think that should be part of that and
3 possibly even insurance reform to deal with this. Bob
4 mentioned about the cumulative nature. It's too big, you
5 can't pull the trigger as we're dealing with it today, so
6 making it a yearly reckoning has a positive aspect and
7 should not be volume driven. And, again, linking it all to
8 the same -- all of us across the silos or the entire
9 spectrum of health care should be linked in together versus
10 separately as we're dealing with it now. And, again, I
11 think we need to have the physicians at the table.

12 I'm interested, as Tom said, we need to get rid of
13 it. Short of that, I think picking a date in the future and
14 working toward that goal makes some sense.

15 DR. BORMAN: I think that the first thing is I
16 agree with the notion that repeal is the necessary step.

17 In terms of thinking about the technical
18 alternatives that have been offered, I would say what can we
19 salvage out of that. I think that notion of risk corridors
20 is something that's worth retaining as we think about
21 whatever comes next.

22 In terms of what we think about next, I think that

1 we need to make sure that whatever we do we're not going to
2 reward people with more money. We haven't figured out a way
3 to give them more discretionary time in their lives. So one
4 thing we need to make sure we don't do is sure not add to
5 the hassle.

6 So I think that, number one, we should make sure
7 that every effort is being made to simplify any regulatory
8 burden and minimize physician hassle and we don't create new
9 physician hassles, because things like EMR and so forth are
10 already creating a sense of hassle.

11 I think also hassle really relates to CMS. Some
12 of the things we've talked about here, particularly the
13 outlier piece, in my view, starts to create an impediment
14 for CMS and other implementation pieces far beyond what
15 probably we would get back in the end. And I think that as
16 much as I like the outlier piece personally, education and
17 things like that can be very short-lived, and the data are
18 pretty clear about that. And I think the hassle is probably
19 not worthwhile.

20 What is worthwhile? Two things, I think probably.
21 Number one is that tort reform resonates well, and it is a
22 real problem. For people who practice medicine you know

1 that it's a problem. And it's a problem in subtle ways, not
2 just overt ways. And, for example, when you get the test
3 report or imaging report that says likely X, next test image
4 could allow better characterization, many people feel
5 they're being dangled out on a limb in our current society.
6 So how do you then leverage that with all the other positive
7 things you talked about? Well, tort reform needs to get
8 linked with an accelerated comparative effectiveness
9 process, and if five societies have guidelines about how
10 best to use nuclear cardiology -- I'm just picking on that
11 as an example -- make it that if you follow any one of those
12 guidelines, you get some sort of protection by virtue of
13 doing that. I think that would go a huge way. It will also
14 give more teeth to the CE process, and we need to -- I think
15 the CE process is probably philosophically perhaps where
16 some of our greatest value comes.

17 I think the second piece of it -- and we need to
18 accelerate it, and we need to make sure that the Patient
19 Center for Outcomes Research -- whatever -- Institute gets
20 adequately funded and moves forward post haste.

21 I think the other piece is that we really need to
22 give some thought -- and I liked the action-forcing and

1 type-of-service as tools because they are a bridge between
2 trying to characterize in some neutral way what various
3 physicians do versus politics and policy. And so I think
4 you have to have some of those, and I think Bob said that
5 very eloquently.

6 I personally would also argue that at the end of
7 the day there needs to be some fundamental think-tanking
8 here. We're smart people. There's lots of smart people
9 thinking about this. We really need to reach outside the
10 box. And Hsiao and that activity is aging, just like the
11 RAND study is aging. It does worry you about their
12 relevance and applicability to planning for a future in
13 which we're imperiling our whole budget and children and
14 grandchildren and all that kind of thing.

15 So I think that some sort of mechanism to
16 encourage think-tanking and do we need to be looking at
17 utility rate-setting models, do we need to be looking at is
18 there a way to enable cost reporting for physicians or some
19 analog of that, or as Nancy described -- I mean, maybe
20 there's off-the-wall ways to do this, but I really think
21 that we need to make some effort.

22 Now, I will say that what Nancy described sounded

1 a lot to me like the VA and Canada, and with no aspersions
2 on the systems, I will say that they each have their
3 difficulties. So I'm not sure I'm ready to jump on that
4 particular bandwagon, but I do think that sort of some blue-
5 sky thinking here, a dedicated effort to do some blue-sky
6 thinking would also serve us well at this juncture.

7 MR. HACKBARTH: Okay, thank you for the
8 presentation. Let me just say a quick word about next
9 steps. Our plan, subject to change as always, is that we'll
10 have a chapter in the June report. We'll have a discussion
11 on this at the April meeting, and in all likelihood I'll be
12 talking to each of you between now and April. Hopefully
13 we'll have enough agreement on ideas that in the June report
14 we can not make definitive recommendations but perhaps more
15 clearly point in certain directions.

16 Then we can discuss this more during our retreat
17 in July, and then assuming all that goes well and we're
18 starting to gel around some ideas, we could work towards
19 draft recommendations for discussion in December and, if all
20 continues to go really well, final recommendations in
21 October. As everybody knows, the current extension expires
22 at year-end.

1 So that's the tentative plan. Lots of work to do
2 to make it happen. Thank you all.

3 And our last session for today is on in-office
4 ancillary services.

5 And let's see. We are roughly a half-hour behind,
6 and so I think it's quite likely that we're going to run
7 over at least a little bit, hopefully not the full half-
8 hour, but probably in the neighborhood of 5:45 to 6:00, I
9 would guess.

10 Ariel, when you're ready, you can begin.

11 MR. WINTER: Thank you. Good afternoon, almost
12 good evening. I want to begin by thanking Carol Frost, Dan
13 Zabinski, Kevin Hayes, Kelly Miller, and Matlin Gilman for
14 their help with this presentation.

15 In last year's June report and at least year's
16 September meeting, we talked, discussed the growth of
17 ancillary services in physicians' offices and potential
18 strategies to address this growth. Over the last several
19 years, there's been an increase in imaging, other diagnostic
20 tests, physical therapy and radiation therapy provided in
21 physicians' offices. From 2000 to 2009, the cumulative
22 growth of imaging and tests was faster than all other

1 categories of physician services. Imaging rose by 85
2 percent during this period, compared with 47 percent growth
3 in all physician services. Although the volume growth of
4 imaging slowed to 2 percent per beneficiary from 2008 to
5 2009, this was preceded by several years of rapid increases.

6 In addition, there is evidence from the literature
7 that imaging services are sometimes ordered inappropriately.
8 The rapid growth of ancillary services has led to questions
9 about payment accuracy, and there are also concerns about
10 physician self-referral of these services. The In-Office
11 Ancillary Services Exception to the Physician Self-Referral
12 Law allows physicians to provide these services in their
13 offices, and we have talked about options to narrow this
14 exception. However, several commissioners have expressed
15 concern that limiting the types of services or physician
16 groups that are covered by the in-office exception could
17 have unintended consequences such as inhibiting the
18 development of integrated delivery systems.

19 Several commissioners have expressed interest in
20 pursuing strategies that are focused on improving payment
21 accuracy and ensuring the appropriate use of services. So
22 we are shifting our focus to these approaches. We plan, or

1 hope, to include a chapter on this topic in the upcoming
2 June report.

3 Before we explore these strategies, I want to
4 first address an issue raised by Mike at the September
5 meeting. He asked us to compare payment rates for ancillary
6 services under the physician fee schedule and the outpatient
7 Prospective Payment System.

8 First, outpatient therapy services -- which
9 includes physical therapy, occupational therapy and speech
10 language pathology -- received the same payment rates
11 regardless of setting, and these rates are established under
12 the physician fee schedule.

13 Next, on average, services in the category of
14 radiation therapy were paid 7 percent more under the
15 physician fee schedule than the outpatient PPS in 2010.

16 With regards to imaging, Medicare makes two
17 payments for imaging studies. First is the professional
18 component which covers the physician's work involved in
19 supervising the test, interpreting the results and writing a
20 report, and second is the technical component which covers
21 the non-physician staff, equipment, supplies and overhead
22 costs.

1 The professional component is paid under the
2 physician fee schedule and is the same across settings.
3 Imaging services provided in physicians' offices receive a
4 technical component payment under the physician fee schedule
5 while studies furnished in hospital outpatient departments
6 receive a facility payment under the outpatient PPS.

7 For most imaging services, the outpatient PPS
8 facility payment is higher than the comparable payment under
9 the fee schedule. However, some imaging services are paid
10 the same amount in both settings due to a provision in the
11 Deficit Reduction Act that caps the physician fee schedule
12 rates for the technical component of imaging at the level of
13 the outpatient PPS rates. We hope to further examine
14 payment rate differences for imaging in the April meeting.

15 Several factors appear to be driving the growth of
16 ancillary services, as listed on this slide, and many of
17 these factors are interrelated. For example, physician
18 self-referral creates incentives to drive higher volume
19 under a system that pays separately for each discrete
20 service. However, a system that pays for services at a more
21 aggregated level, such as on a per-episode basis, would
22 encourage providers to use resources more efficiently.

1 Therefore, the first policy option is aimed at
2 moving Medicare in this direction, and this option is to
3 combine discrete services often furnished together during
4 the same encounter or episode of care into a single payment
5 rate. The second option we're going to talk about is to
6 reduce payment rates for the professional component of
7 multiple imaging studies done in the same session. The
8 third option is reduce payment rates for imaging and other
9 diagnostic tests performed by self-referring physicians.
10 And the fourth option is to require prior authorization for
11 physicians who order many more advanced imaging services
12 than their peers.

13 The first option can be divided into two related
14 approaches. First is packaging, and this refers to
15 combining multiple services provided during one encounter
16 with a provider into a single payment. And second is
17 bundling which refers to combining services furnished during
18 multiple encounters into a single payment. These approaches
19 are designed to improve payment accuracy and also to
20 encourage efficiency in the delivery of care.

21 Packaging could eventually serve as building
22 blocks for bundled payments. With regards to packaging, the

1 AMA/Specialty Society Relative Value Scale Update Committee,
2 or RUC, has established a process to combine codes
3 frequently performed together into a single comprehensive
4 code.

5 A RUC work group has been reviewing services that
6 are billed together at least 75 percent of the time to
7 determine if these services should be combined to account
8 for duplication in physician work. After the RUC work group
9 identifies pairs of services, it refers these codes to the
10 CPT editorial panel for the development of comprehensive
11 codes. Once these comprehensive codes have been created,
12 the RUC recommends work RVUs and practice expense inputs for
13 the new codes to CMS. CMS must then review and approve the
14 new values through its rule-making process.

15 For 2011, for example, CMS adopted RVUs for a new
16 comprehensive code that includes 2 component services -- CT
17 of the abdomen and CT of the pelvis. The work and practice
18 expense RVUs for this new comprehensive code are lower than
19 the sum of the RVUs for the component codes that it
20 includes.

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

1 when services are performed together. But it's important to
2 note that this process is methodical and deliberative and is
3 occurring over the course of several years.

4 Now I'll briefly describe bundling. One type of
5 bundled payment includes services furnished by a single
6 provider across multiple encounters. For example, under the
7 physician fee schedule's global surgical policy, physicians
8 receive a global payment rate for many surgical procedures
9 that include some preoperative care, the surgery itself and
10 a set of postoperative visits.

11 Another type of bundled payment includes services
12 delivered by multiple providers. For example, based on a
13 Commission recommendation, PPACA directed the Secretary to
14 establish a pilot program to test bundled payments for all
15 services associated with a hospitalization.

16 CMS could also explore creating bundled payments
17 for ambulatory services provided during an episode of care.

18 Bundled payments could perhaps be developed for
19 short-term acute episodes, like low back pain, or common
20 high-cost chronic conditions.

21 We do recognize there would need to be a fair
22 amount of work to identify and price cohesive bundles of

1 services, and to address situations in which multiple
2 providers furnish services within a bundle. This leads us
3 to the Chairman's first draft recommendation: The Secretary
4 should request that the RUC and CPT editorial panel
5 accelerate and expand their efforts to combine discrete
6 services into comprehensive codes, and should develop
7 bundled payments that include multiple ambulatory services
8 furnished during an episode of care.

9 With regards to the implications, we expect this
10 would decrease program and beneficiary spending unless the
11 policy changes were budget neutral. For example, under
12 current law, reductions to RVUs for comprehensive codes are
13 offset by increases for other codes. We do not anticipate a
14 reduction in beneficiaries' access to services or providers'
15 willingness, or ability, to furnish those services.

16 Because the process of creating package and
17 bundled payment rates is a long-term effort, you may wish to
18 consider interim approaches that could be accomplished more
19 rapidly. The Commission has previously observed that
20 savings of physician time are likely when multiple services
21 are provided together instead of independently, for example,
22 when a physician performs an interpretation of two imaging

1 studies that occurred during the same session. Certain
2 activities such as reviewing the patient's history and
3 discussing the findings with the referring physician likely
4 occur only once. However, the current RVUs assume that
5 these services are provided independently and that each
6 activity is performed twice.

7 The Commission has also noted that there are
8 likely to be efficiencies in physician work when diagnostic
9 tests are ordered and performed by the same physician. In
10 both of these cases, the RVUs could be adjusted to capture
11 duplications in physician work. One way to accomplish this
12 is to create comprehensive codes with new RVUs that reflect
13 these efficiencies, which is something we just talked about.
14 But because this process is proceeding on a code-by-code
15 basis and is time consuming, CMS could take action sooner by
16 reducing RVUs for these services until comprehensive codes
17 are developed.

18 The first of these approaches would reduce payment
19 rates for the professional component of multiple imaging
20 studies performed in the same session. Medicare currently
21 applies a multiple procedure payment reduction to the
22 technical component of imaging studies but not to the

1 professional component. The way this works is CMS reduces
2 the payment rate for the second and subsequent services in
3 the same session by 50 percent. This is meant to account
4 for efficiencies in practice expense; that is the clinical
5 labor, equipment, supplies and overhead costs.

6 In a 2009 report, GAO found efficiencies in the
7 professional component when two imaging services are
8 performed together because certain activities, such as
9 reviewing the patient's history and symptoms, are not
10 duplicated. They estimated that Medicare could save over
11 \$175 million per year if the program accounted for these
12 efficiencies in physician work.

13 Thus, to account for duplications in physician
14 work, CMS could expand the multiple procedure reduction to
15 the professional component of imaging services, and this
16 would align the policy for both components of an imaging
17 study. So the second draft recommendation reads: The
18 Congress should direct the Secretary to apply the multiple
19 procedure payment reduction to the professional component of
20 diagnostic imaging services provided in a single session.

21 Regarding the implications, we expect this would
22 decrease program and beneficiary spending unless the policy

1 change was budget neutral. Under current law, the savings
2 from this policy would be redistributed to other fee
3 schedule services, but you could consider recommending that
4 the savings be returned to the trust fund. We do not
5 anticipate that this would reduce beneficiaries' access to
6 clinically appropriate services. We do expect this would
7 reduce revenue for providers who perform the professional
8 component of multiple imaging studies in the same session.

9 A related approach would reduce payment rates for
10 imaging and other diagnostic tests done by self-referring
11 physicians. A key difference from the previous option is
12 that this would apply not only to imaging but also to other
13 diagnostic tests such as anatomic pathology and cardiac
14 stress tests. The rationale for this policy is that there
15 are likely to be efficiencies in physician work when a
16 diagnostic test is ordered and performed by the same
17 physician.

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

1 information during a prior E&M service.

2 The work RVU for the test also includes discussing
3 findings with the referring physician, and this is
4 unnecessary if the referring physician is the same one who
5 performed the test. Therefore, it may be appropriate to
6 reduce the payment rate to account for these duplicative
7 activities.

8 We examined the potential impact of this policy
9 option on imaging services although we do recognize that it
10 would also apply to other diagnostic tests paid under the
11 fee schedule. This table shows the share of office-based
12 imaging services in 2008 in which the professional component
13 was performed by the same physician who ordered the study.
14 We excluded services performed in independent diagnostic
15 testing facilities and hospitals. Across all office-based
16 imaging services, we found that 37 percent of studies were
17 performed by the same individual physician who ordered the
18 service.

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

1 An important issue to keep in mind is that this
2 recommendation would only apply to cases in which the
3 physician who bills for performing the service is also
4 listed on the claim as the ordering physician. Thus, there
5 would be an incentive for a group practice to make sure that
6 the ordering physician on a claim is different than the
7 performing physician even if they are in fact the same
8 person. To discourage this type of behavior, you may want
9 to discuss whether to expand this policy to cases in which
10 the physician who orders the service shares a practice with
11 a physician who performs it.

12 With regards to the implications, this would
13 decrease program and beneficiary spending unless the policy
14 change was budget neutral. We do not anticipate a reduction
15 in beneficiaries' access to clinically appropriate services.
16 We do expect this would reduce revenue for physicians who
17 both order and perform imaging or other diagnostic tests.

18 And now we'll move on to the fourth approach.
19 Under this option, Medicare would require physicians who
20 order significantly more advanced imaging services than
21 their peers to participate in a prior authorization program.
22 And by "advanced imaging," we're referring to MRI, CT and

1 nuclear medicine studies.

2 This policy would focus on outlier physicians who
3 order many imaging services and ensure that they are using
4 imaging appropriately. Because both self-referring and non-
5 self-referring physicians may be high utilizers, this
6 approach would apply to both types of physicians.

7 And we're not saying that all physicians who order
8 a lot of imaging are using imaging inappropriately.
9 Instead, we're trying to limit the burden of prior
10 authorization by focusing it on a subset of physicians.

11 In 2008, GAO recommended that CMS examine the
12 feasibility of adopting a prior authorization program to
13 manage imaging services, and a prior authorization policy in
14 Medicare would likely involve three steps. First, CMS would
15 identify physicians who are outliers in terms of their use
16 of advanced imaging. Second, these physicians would have to
17 submit their request for ambulatory, non-emergency imaging
18 services to CMS or a contractor for review. And third, if
19 the imaging request is clinically appropriate, CMS would
20 approve it for payment, but if not, the payment would be
21 denied.

22 As an interim step before prior authorization, CMS

1 could provide confidential feedback to outlier physicians on
2 whether they are using imaging appropriately.

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

14 Some plans use prior notification instead of prior
15 authorization. In this case, the plan or the RBM reviews
16 imaging requests and provides feedback on whether the
17 studies are appropriate, but it does not deny payment.

18 Unfortunately, there are no independent studies
19 that measure the long-term impact of prior authorization
20 programs using a control group. Plans interviewed by GAO as
21 part of their study reported that the annual growth of
22 imaging services slowed down significantly after these

1 programs were implemented, with most of the decrease
2 occurring in the first year.

3 A published case study of three health plans that
4 adopted prior authorization found that the number of CT and
5 MRI studies declined in the first year after the program was
6 implemented. However, results for the second year of the
7 program are mixed. Volume continued to decline in one of
8 the plans but increased in the other two plans.

9 There would be several challenges involved in
10 developing a prior authorization program for Medicare. I'm
11 going to describe a couple of them, but they are all
12 discussed in more detail in your paper.

13 A key issue is the administrative burden on
14 physicians who would be required to participate in such a
15 program, and the perceived challenge to their clinical
16 autonomy.

17 Next, there are concerns about the quality of
18 clinical guidelines that are used to approve imaging
19 studies. There is often a lack of empirical information on
20 the impact of imaging, on clinical decision-making and
21 patient outcomes. Because of this information gap, efforts
22 to develop guidelines often rely on clinical judgment and

1 expert consensus.

2 Another issue is that prior authorization would
3 require significant administrative resources for CMS, and
4 it's difficult to predict whether prior authorization would
5 reduce imaging spending by a large enough margin to offset
6 these administrative costs.

7 In 2008, CBO estimated that prior authorization
8 would reduce Medicare spending by about \$1 billion over 10
9 years, accounting for administrative costs. It is important
10 to note that CBO assumed that such a program would apply to
11 all physicians rather than a targeted subset of physicians.

12 Finally, CMS would have to determine how to
13 identify physicians who order significantly more advanced
14 imaging services than their peers. One method would be to
15 measure the amount of imaging used by physicians on a per-
16 episode basis. Another approach would be to measure the
17 level of imaging used on a per-patient or per-capita basis
18 by physician. Or, CMS could develop a combination of these
19 two approaches.

20 The fourth draft recommendation reads: The
21 Congress should direct the Secretary to establish a prior
22 authorization program for physicians who order substantially

1 more advanced imaging services than their peers.

2 With regards to the implications, we expect this
3 would decrease program and beneficiary spending. We do not
4 anticipate a reduction in beneficiaries' access to
5 appropriate imaging services. And we expect, anticipate
6 there would be an administrative burden on providers who are
7 required to obtain prior approval under this program.

8 So to sum up, we've described four approaches for
9 improving payment accuracy and appropriate use of ancillary
10 services. We'd like to get your feedback on these
11 approaches and on the draft recommendations we've presented.
12 And of course, I'd be happy to take any questions.

13 MR. HACKBARTH: Thank you. Good job.

14 There ought to be a rule against having this on
15 the heels of SGR.

16 [Laughter.]

17 MR. KUHN: [Inaudible.]

18 MR. HACKBARTH: Yeah, right, poor leadership.

19 This is a topic that fills me with ambivalence.
20 On the one hand, I am convinced that self-referral has
21 contributed to our problems with growing volume, including
22 some of it inappropriate. I think the evidence, at least to

1 me, is pretty persuasive on that. Incidentally, my hunch is
2 also that SGR has contributed to self-referral by causing
3 physicians to want to find other ways to generate income.
4 So some of these things are linked to one another.

5 On the other hand, I am wary of sweeping solutions
6 to the problem of self-referral, like outright bans, because
7 I don't think the problem is, strictly speaking, self-
8 referral per se. The problem is the toxic combination of
9 self-referral, fee-for-service payment and mispricing of
10 services so that some services present really rich profit
11 opportunities. It's those things together that get us into
12 trouble.

13 You heard me say often, all too often probably, my
14 health care management experience is in a group that had all
15 the services in-house, and we were self-referring for
16 everything. We thought that was good for patients for a
17 variety of different reasons. But on the other hand, we
18 operated under a global payment system and had a salaried
19 clinical staff where the incentives were not to overuse the
20 services but use them in an appropriate way. So the
21 dynamics were very, very different.

22 I'm wary of potential solutions to self-referral

1 that could damage organizations that are organized to do
2 things the right way. That would be really unfortunate from
3 my perspective.

4 So in trying to steer between my concerns about
5 self-referral on the one hand and my concerns about too
6 sweeping approaches on the other, I came, with help from
7 Ariel and Mark and others, to this list of four
8 recommendations, several of which -- let's see.

9 The first and the fourth are sort of targeted at
10 the basic issue of fee-for-service incentives. If you have
11 small, discrete units of service and separate payments for
12 each one, you tend to get more of them. By bundling,
13 packaging services together, that's a common tool we've used
14 in many contexts to try to diminish, if not eliminate, those
15 incentives. Prior authorization applies an administrative
16 check on the fee-for-service incentives to do more.

17 The two middle options go at the issue of
18 mispricing the services and try to better match the amount
19 we pay to the actual costs incurred, thus potentially
20 wringing out some of the excess profit opportunity. So
21 rather than ban self-referral, let's try to target the
22 problems per se.

1 So that's the thinking behind this set of four.

2 Some people may think it's medicine is too weak
3 for the problem. I invite your comments on that.

4 Just one last thought before we start the comment
5 or question, clarifying question round. Recently, all of
6 the talk about ACOs has caused me to think a little bit
7 differently about this, not come to different conclusions,
8 but it gives me sort of a different vantage point on this.

9 Let's say we were to go more aggressively at self-
10 referral, go beyond these options, to the extent that ACOs
11 really become a common form of organization of care. Set
12 aside the payment for a second. Then you could perhaps be
13 more aggressive on self-referral and say if you're organized
14 as part of an ACO and under a payment system where you have
15 better financial incentives, we will exempt you from the
16 tougher self-referral rules. So that's just another thought
17 that's rattling around in my head.

18 So let's begin the round one clarifying questions.
19 I can't remember which side we're starting on. Tom looks
20 really eager to start the clarifying questions.

21 DR. DEAN: Do we know where the whole concept of
22 prior authorization stands in the private community because

1 there's a number of private plans that actually tried it
2 for a while and then backed away from it because of just the
3 hassle factor? Do you know?

4 MR. WINTER: So as far as I know, it's still
5 fairly prevalent, and this is based on GAO's study which is
6 a couple of years old. But they interviewed 17 plans and
7 RBMs, and they found it to be fairly prevalent.

8 I've seen an estimate that about 90 million
9 covered commercial lives are subject to some form of RBM
10 which might be prior authorization. It might be
11 privileging. It might be something else. And I'll try to
12 find that citation for you.

13 Then HSC did a study which also found it to be
14 fairly prevalent in the markets where they visit, that they
15 cover.

16 MR. HACKBARTH: So Tom, in the '90s, 1990s, prior
17 authorization was a widely used tool. Some would say an
18 indiscriminately used tool.

19 And I think you're right. As we went through the
20 decade, many health plans scaled back their prior
21 authorization programs; in some cases, eliminated them
22 altogether.

1 DR. DEAN: [Inaudible.]

2 MR. HACKBARTH: They concluded that the
3 administrative costs and the damage to their reputations and
4 relationships with physicians and patients, the costs were
5 too high relative to the benefits.

6 I think what we've seen in more recent years is
7 much more targeted use of prior authorization, not the
8 sweeping programs that existed in the '90s.

9 DR. DEAN: [Off microphone.] Okay.

10 Do you think that's a fair statement, Bob?

11 DR. BERENSON: Yeah. I would just emphasize that
12 there's still a lot of prior auth going on, and I'm pretty
13 sure that this is the one area that the health plans feel
14 they're getting a good return -- is in imaging. So I hadn't
15 heard that they had been abandoning this particular
16 approach.

17 DR. DEAN: There was some publicity a few years
18 ago. I think United Healthcare stopped prior authorization
19 on -- and I can't remember the details. [Off microphone.]
20 It was a big thing.

21 MR. HACKBARTH: Scott.

22 MR. ARMSTRONG: Just anecdotally, around imaging

1 in the Puget Sound marketplace, we've recently turned back
2 on prior authorization, but it's really been complemented
3 with fairly transparent reporting of volumes and comparing
4 different groups, use rates and so forth, so that we can
5 refine it and get it more focused. But I would say it's not
6 what it used to be, but it's still alive.

7 DR. DEAN: Okay.

8 MS. UCCELLO: A quick clarification of how the
9 independent imaging facilities are paid. Physician fee
10 schedule? Is that --

11 MR. WINTER: Yes. Correct.

12 MS. UCCELLO: Okay. So there's no difference.

13 MR. WINTER: There is no difference between an
14 independent diagnostic testing facility which is a free-
15 standing imaging center and a physician's office.

16 MS. UCCELLO: Okay.

17 MR. WINTER: They're subject to different rules to
18 get into the program, but the payments are equivalent.

19 MR. ARMSTRONG: It may be in here. Did this
20 evaluation consider any kind of quality reporting or quality
21 information relating utilization either inversely or not to
22 quality outcomes?

1 MR. WINTER: No, that's not something that we
2 considered explicitly in terms of the relationship between
3 the use of ancillary service and downstream outcomes.

4 MR. ARMSTRONG: Well, I think downstream would be
5 ideal and probably most impossible, but just there's -- you
6 answered my question.

7 MR. WINTER: With regards to physical therapy,
8 which we haven't talked about much today but we've talked
9 about in prior sessions, on this topic in our 2006 report --
10 June, I believe -- we did talk about different options for
11 payment reform, and one of those was trying to get more
12 clinical information and more information about outcomes, so
13 that the payment could be better related to the improvements
14 in functional ability and those kinds of outcomes. But it's
15 not something we've talked about in this chapter.

16 MR. ARMSTRONG: Okay.

17 MS. BEHROOZI: It might be in the paper, and I
18 can't find it. What is the overlap in terms of
19 Recommendation 4, I guess it is, the outlier prior
20 authorization? Anyway, whichever number it is.

21 I understand that the recommendation is to apply
22 it both self-referring and non-self-referring physicians.

1 Do you know what the overlap of a sort of robust outlier
2 group and self-referring physicians is? I mean is it mostly
3 self-referring physicians? Is it, you know, really a small
4 overlap?

5 MR. WINTER: Right. So it depends on how you
6 define outlier of course. In our prior work and other
7 studies found that self-referring physicians order more
8 imaging studies than non-self-referring physicians for an
9 episode of care, on a per-patient basis. So you'd expect to
10 find them over-represented, you know, in an outlier pool,
11 but I don't have specific numbers.

12 But I can go back and try to look at that and
13 perhaps bring something back for you next time.

14 MS. BEHROOZI: And I'll just say the next round
15 comment, it just seems like if you would say that it would
16 only apply to self-referring physicians then it somewhat
17 insulates the recommendation from some criticisms about the
18 methodology that you use to get to it. If you're starting
19 with self-referring physicians, it's sort of built in. You
20 know.

21 DR. STUART: In the old days, one of the ways to
22 get around this was to use certificate of need, and I didn't

1 see anything in the chapter about certificate of need. I
2 know that the State of Maryland has had a prohibition on
3 physician purchase of imaging equipment since 2006. I don't
4 know what's happening in other states. So that would be a
5 question.

6 And then kind of a follow-on, if you have looked
7 at that, do you have any sense about whether that's
8 successful in terms of constraining increases in
9 utilization?

10 MR. WINTER: It's not something I've looked at
11 recently. Many states have been loosening or repealing
12 their certificate of need laws, and where they do exist
13 there are often exceptions. So sometimes they just apply to
14 a hospital and not to a physician practice or a free-
15 standing center. They really vary a lot. So it's hard to
16 do, you know, an analysis of their impact when there are so
17 many differences between states.

18 I wasn't aware of the change to the Maryland CON
19 law. So it's something I'll look into and see if I can talk
20 to the state officials about what the impact has been.

21 DR. STUART: The only reason that that might be
22 interesting is that it's currently being debated in the

1 legislature to get rid of it.

2 MR. KUHN: Just one quick question. Kind of the -
3 - you touched on this a little bit in the written material
4 that came in advance, but just a little bit more
5 clarification of impact on beneficiaries. That is if my
6 understanding -- and I've talked to an RBM over the last
7 couple of weeks. You know.

8 They turn this around pretty fast. You know.

9 They make a request for a prior authorization.
10 They can get back to them within some of them 15 minutes.
11 Some of them, it's four hours. But they pretty much
12 adjudicated the whole process within 24 hours, at least some
13 of them have performance metrics at 95 percent adjudication
14 in 24 hours. So they move pretty quickly.

15 But I guess within the Medicare program and with
16 beneficiaries, there is an additional penal right I assume
17 Medicare beneficiaries have where they could ultimately go
18 to an ALJ. So I guess one question is how long would this
19 carry out and could it delay the imaging function for the
20 beneficiary and how does the current appeal process work for
21 beneficiaries?

22 Then the second question, and you kind of raised

1 this in the paper a little bit, is the various compliance
2 programs CMS has going on. For example, say an RBM approves
3 it, and then six months later a RAC contractor comes along
4 and says sorry, we think that was inappropriate. How do
5 they sync up all their processes as they go forward?

6 MR. WINTER: Both excellent points. There were
7 concerns raised by CMS in response to the GAO
8 recommendation. In the response, CMS raised the issue that
9 their appeals process could be more favorable to Medicare
10 beneficiaries than a commercial plan's appeals process and
11 therefore could lead to if a service was denied through a
12 prior authorization process that was appealed farther down
13 the line. There could be more. More of those denials could
14 be overturned than in a commercial setting.

15 My understanding of the appeals process is that it
16 goes into effect when payment for a claim is denied, and so
17 I think the way it would interact with the prior
18 authorization program is if the program denied -- the way it
19 generally works is the plan denies payment if it doesn't
20 meet the criteria. So if the provider went ahead and did
21 the service anyway, then they would have the basis for an
22 appeal by the beneficiary, and then it would work its way

1 through the process.

2 So I think it would be sort of sequential, that
3 you would have the prior authorization process first, and
4 then claims that were denied but the service was actually
5 provided would then go through the appeals process.

6 With regards to the post-payment review question,
7 there was another issue raised by CMS, which is if the RBM
8 or if the program denies payment initially through prior
9 authorization -- I'm sorry -- approves payment for a
10 service, can it come along later and deny it retroactively.
11 And that certainly is a very big question, and I don't have
12 an answer for that.

13 MR. KUHN: So on the -- I'm sorry.

14 MR. HACKBARTH: Go ahead.

15 MR. KUHN: But I was going to say on the
16 beneficiary.

17 So presumably what would happen there is that a
18 physician wants to do a scan or some kind of imaging
19 procedure. The RBM, or whoever, denies it. And then they
20 go to the beneficiary and say, I really think this ought to
21 be done; will you sign an ABN, advance beneficiary notice?
22 Then they do it. The beneficiary is liable potentially, but

1 they go through the process, and that would then trigger the
2 beneficiary appeal process, I assume.

3 MR. WINTER: I think that's how it would work.

4 Now just within the prior authorization process
5 itself there are different levels, as you're probably aware.
6 So there's the initial process where they will either call
7 up, or you use a web-based interface, and answer a series of
8 questions, and based on the answers the test will be
9 approved or not. But then if it's denied, then the next
10 level would be talking to usually a nurse reviewer. And
11 then beyond that, the requesting physician can talk to a
12 physician reviewer, and argue, make the case. Sort of
13 within the prior authorization process, there's a series of
14 steps that can be pursued.

15 MR. HACKBARTH: So check that CMS responds to the
16 GAO report. I think he signed it. I think it's not a
17 coincidence that --

18 [Laughter.]

19 MR. WINTER: That's why I read it carefully before
20 the meeting.

21 DR. MARK MILLER: I was just going to say that's
22 why Ariel read it.

1 [Laughter.]

2 DR. CASTELLANOS: Ariel really gave us a lot of
3 information and thought. Some of my comments may be one or
4 two, but I'll try to separate.

5 You talk about the share of the office space
6 imaging services ordered and performed by the same
7 physician. Now in the text or the material that was given
8 to us -- I think it's on 15 -- you talked about physicians
9 also who share a practice. Is that the same?

10 MR. WINTER: Yeah. So in your mailing materials,
11 it's on page 24, the more complete table, if you want to
12 refer to that.

13 What we've shown here are the share of cases of
14 office-based imaging where it was the same, identical
15 physician who ordered the service and billed for the
16 professional component. That's what we're focused on here.

17 The additional column in the table in your paper
18 refers to cases where the ordering physician is in the same
19 practice as the physician who performed the professional
20 component. So they shared a tax number, basically. That's
21 how we identified the same practice. And that was because
22 we were still debating how expansive do we want this

1 recommendation to be, or this policy option to be.

2 DR. CASTELLANOS: So to make it clear, it's the
3 doctor who orders it and does it himself that this applies
4 to; it does not apply to physicians who share this practice.
5 Is that correct?

6 MR. WINTER: The way the draft recommendation
7 reads, that's correct, and we've raised for your discussion
8 whether you want to think about making it more expansive.

9 DR. CASTELLANOS: On slide 15, you -- I know we've
10 -- I've asked you in the past, and I think Bob has asked you
11 in the past. Since about 40 percent of the doctors are now
12 hospital-employed, and that's a big number, why don't we
13 include IDFs and hospitals? You're just using offices here.

14 I mean 40 percent of the doctors in the United
15 States are hospital-based or employed. So shouldn't they
16 come under that too?

17 MR. WINTER: Okay. So in terms as an analytical
18 exercise, I don't have, and there are no data, on the claims
19 indicating whether a physician is employed by a hospital.
20 I'm not aware of any administrative data set that would tell
21 us this. So in terms of analytically I can't give you a
22 percentage the way I can for physicians who are both

1 ordering and performing.

2 In terms of a policy recommendation, that's
3 something you all can talk about -- whether you want to make
4 it more expansive and apply it to physicians who are
5 employed by a hospital and the test is billed by that
6 hospital.

7 [Off microphone.] I'll stop there.

8 DR. CASTELLANOS: I just think it's I hate to use
9 the word "discriminatory," but you're leaving out 40 percent
10 of the doctors in the United States, and you're forcing
11 people now to go from private practice into the hospital to
12 avoid this. So I don't think that's the fairest way to do
13 it.

14 MR. HACKBARTH: I see your point to a degree, Ron.
15 Presumably, people who are employed, physicians who are
16 employed want their employer to do well, and so even a
17 physician who's employed and paid on a salary basis might be
18 tempted to help his or her hospital employer by saying, oh,
19 you know, order the extra test at the margin. So in that
20 sense, you've got potentially a similar problem.

21 Whether it's exactly the same problem comes down
22 to how the physician is compensated. If the physician is

1 compensated on a salary, it might be a weaker incentive in
2 the hospital. If they're paid on some productivity basis,
3 where in essence they're rewarded for volume in the
4 hospital, then it might be more like the office practice.
5 So that's just a question of how things work at the --

6 DR. BERENSON: And increasingly, they're being
7 paid on productivity is what's going on.

8 MR. HACKBARTH: Right.

9 DR. CASTELLANOS: And that's exactly what happens.
10 I think if you're going to do this I think you need to
11 include the hospital too. That's my point.

12 Prior authorization, prior notification, just a
13 clarification. There is a recent AMA survey that shows
14 their experience with that.

15 You know, I like prior notification for everybody
16 because you get a feedback to everybody who is using the
17 service, and you may identify some people who are high users
18 or perhaps not high users but inappropriately ordering, and
19 that physician gets that feedback from prior notification,
20 and then he, if he or she doesn't deal with it, then you can
21 go to prior authorization.

22 But I like prior notification. I really do.

1 That's enough for round one.

2 DR. KANE: Yeah, just one quick question on slide
3 6, that the RUC has been reviewing services billed together.
4 By "billed together," does that mean it's the same doctor
5 performing the same service or does it mean --

6 MR. WINTER: Yes,

7 DR. KANE: Okay, so it's all the same.

8 MR. WINTER: Same physician, same patient, same
9 date of service.

10 DR. KANE: So there's another potentially up to 25
11 percent of people who are not. For that combined service,
12 there's two people involved, and how would they deal with a
13 combined payment? I'm just trying to understand how it
14 would work.

15 MR. WINTER: When they create a comprehensive
16 code?

17 DR. KANE: Yeah.

18 MR. WINTER: Okay. You can still bill separately
19 for let's say the example of CT of the pelvis, CT of the
20 abdomen which were recently combined into a comprehensive
21 code. If you do both together, you have to bill for the
22 comprehensive code. If you just do one, you just bill for

1 the individual component code.

2 DR. KANE: But if you do one and somebody else
3 does the other, I mean -- well, I don't know.

4 MR. WINTER: If a different physician does the
5 other?

6 DR. KANE: Yeah.

7 MR. WINTER: Well, then they each bill separately
8 for the component code.

9 DR. KANE: So I guess that could be a little bit
10 of an issue if they're both -- unless they're in the same,
11 if they're in the same practice?

12 MR. WINTER: I believe even if they're in the same
13 practice, if it's a different -- it's a good actually. I'll
14 look into this, but I suspect if it's a different NPI on a
15 claim then they can bill under the component code, under
16 each component code. So it's a separate claim for each
17 rather than a single claim for the comprehensive code.

18 MR. HACKBARTH: So what you're suggesting, Nancy,
19 is this is a way it can be avoided.

20 DR. KANE: Yeah.

21 MR. HACKBARTH: Peter.

22 MR. BUTLER: Okay, so go back to 15 again. I'm

1 still not sure I'm clear on this.

2 So if an orthopedist in an orthopedic practice where
3 they own their own MRI orders an MRI, but the radiologist
4 reads the image, so is the billing physician, it wouldn't be
5 -- they would not -- it wouldn't apply to them.

6 MR. WINTER: Correct. They would not be shown.
7 They're not included in these percentages, and they would
8 not be included in the draft recommendation.

9 MR. BUTLER: Yeah, that's a problem for me, but
10 I'll get to that in round two. Okay.

11 Secondly, we've let physical therapy and radiation
12 therapy, oncology, kind of -- they're not a part of any of
13 this. We've had concerns about those in the past, but
14 they're not part of these recommendations, right?

15 MR. WINTER: Not explicitly though you could think
16 about doing packaged, creating packaged or bundled payments
17 that include physical therapy services or radiation therapy
18 services.

19 And one reason we didn't have the second and third
20 recommendations relate to payment accuracy, we did not have
21 one for physical therapy or occupational therapy because CMS
22 just made a change where they applied the multiple procedure

1 reduction to multiple outpatient therapy services provided
2 on the same day to the same patient, and the reduction is 25
3 -- actually, now it's 20 percent. So they've addressed some
4 of those concerns through rule-making.

5 MR. BUTLER: They would be another good candidate
6 for prior authorization -- physical therapy -- but I'll let
7 that go.

8 Third is on page 41 of the text and just kind of
9 it shows the top quarter and then the top tenth percentile
10 in terms of users, and then the percentage of spending that
11 they represent. So go to the bottom right-hand corner and
12 see if I'm reading this right. It says in MRI the top tenth
13 percentile represents 10.4 percent of the spending. Is that
14 what that says?

15 MR. WINTER: Right.

16 MR. BUTLER: So it's hardly even -- it says that
17 the top 10 uses 10 percent.

18 MR. WINTER: This is a function of the sample we
19 were using. The sample only includes, in this case, MRI
20 services. So every physician who was in our sample billed
21 for at least one MRI service for a patient.

22 So it's not the full -- you know. We're not

1 looking at the full universe of physicians who bill Medicare
2 and then just saying. We're taking the 10 percent who
3 billed for the highest mean number of MRI services per
4 patient. We're already looking at sort of a skewed subset,
5 and so I want to caution you about drawing too much,
6 inferring too much from these results.

7 MR. BUTLER: The way I look at that, it looks like
8 they used a proportionate share. Everybody uses -- and I'm
9 misinterpreting, or the data aren't --

10 MR. HACKBARTH: Ariel is saying it's a high-use
11 group that they're the top 10 percent of.

12 MR. BUTLER: Okay.

13 DR. NAYLOR: Thank you for this report. If we
14 were to look at this set of recommendations in a bundled
15 way, 2 and 3, would you be recommending reducing payments
16 for professional component and in addition, if these are
17 self-referring physicians, to further reduce payments?

18 MR. WINTER: So actually, I anticipated this
19 question.

20 DR. NAYLOR: I'm glad.

21 MR. WINTER: And I have a draft. I have a slide
22 that illustrates how this would work, but keep in mind that

1 the percentages --

2 DR. MARK MILLER: [Inaudible.]

3 MR. WINTER: I wanted to keep it in originally. I
4 had to take it out for time constraints

5 Keep in mind the percentage reductions we're
6 showing you are illustrative, are not part of the
7 recommendation, and what CMS would end up doing might be
8 greater or lesser than what we've shown.

9 So the way we see this working is the third
10 recommendation, which applies only to self-referring
11 physicians, would only apply to the first service billed by
12 a self-referring physician within a session. The overlap
13 really only occurs for imaging. So we're focused now just
14 on imaging studies.

15 So let's assume the payment for the professional
16 component is \$100, and you're just doing one imaging, just
17 one imaging study for the session. So the non-self-
18 referring physician gets the \$100. But if you reduce that
19 payment rate by 25 percent for a self-referring physician,
20 to account for duplications in physician work, then the
21 self-referring physician gets \$75 for that first study
22 within the session.

1 Now let's say there's a second study within the
2 session, and let's say that payment is reduced by 50 percent
3 for the professional component, which is consistent with the
4 reduction for the technical component. Then the non-self-
5 referring physician would receive \$50 for that second study
6 and then the self-referring physician would also receive \$50
7 because we're not going to apply that self-referring
8 specific policy to the second and subsequent services.

9 And that's because you're already counting for
10 duplications in physician work through the multiple
11 procedure reduction policy. So it doesn't make sense to
12 apply both policies because you're really counting for the
13 same efficiencies. For similar efficiencies, let's say, in
14 each policy.

15 DR. NAYLOR: So you're encouraging multiple
16 imaging. I'm only teasing.

17 And I want you on record. I didn't -- this wasn't
18 planted. [Off microphone.] Thank you.

19 DR. BAICKER: Just a quick question on
20 Recommendation 4. I don't know. I forget what slide it is.

21 I would imagine, not having looked at the original
22 studies, that there are two reasons that you get a reduction

1 in use when you require prior authorization. One is when
2 the physician is kind of on the fence about it and thinks
3 maybe it's not going to pass muster, it's not really that
4 important; they don't bother trying to do the procedure.
5 And then the second reason is they try it and it gets turned
6 down.

7 And those have different implications for the
8 beneficiary and also different implications about how good a
9 job the tool is doing in targeting that marginal use. I
10 don't know what share.

11 So two useful pieces of information that may be in
12 the studies that you could share is did the companies that
13 tried this see a reduction in the number that were tried.
14 It's so late in the day. The number people tried to do and
15 then among those how many actual denials were there.

16 And from that, I might be able to infer a little
17 bit about whether there are a lot of cases that are truly
18 labelable as inappropriate use, or whether you're marching
19 down a very smooth curve of appropriateness and physicians
20 are doing an okay job at balancing that on the margin.

21 MR. WINTER: Both good questions. The two
22 published studies that have looked at the impact of either

1 prior authorization or prior notification have not
2 disaggregated between these two factors. They're looking at
3 a much more aggregate level of just here's the volume before
4 implementation, here's the volume after implementation.

5 The study though that looked at the impact of
6 prior notification, so there were never denials. There's
7 just you had to submit information, you got feedback. So
8 all of that impact would be related to a sentinel effect or
9 physician education. They found that growth went from about
10 10 percent per year before the program to basically flat
11 afterwards, but I think it only looked at a year or so. It
12 wasn't a long-term study, and so I wouldn't draw too much
13 from that.

14 The second issue you raised is: Is there sort of
15 a continuum of appropriateness? Absolutely. I mean based
16 on the way the guidelines are constructed they go from 1 to
17 9, 1 being least appropriate and 9 being most appropriate.
18 And the RBMs, they draw the line in different places, and
19 some are more aggressive than others. So it's a difficult
20 issue.

21 MR. GEORGE MILLER: Two quick questions. On slide
22 18, can you tell me what happened to the GAO recommendation

1 concerning the feasibility of prior authorization from 2008?
2 Was that done?

3 MR. WINTER: I don't believe so.

4 MR. GEORGE MILLER: Okay.

5 MR. WINTER: CMS responded to that and said we
6 have a lot of concerns here. And if they looked at it, it
7 was internal. There was no public report summarizing their
8 views.

9 But just to note, there was a budget proposal in
10 the President's budget for 2010 that would use RBMs to
11 ensure appropriate use of imaging, and it was estimated to
12 save about \$250 million over 10 years. It did not define or
13 explain what that meant. So presumably, it was prior
14 authorization, but we don't really know.

15 MR. GEORGE MILLER: And then with this, to follow
16 up on that, with these recommendations, do we know if CMS
17 has the bench strength to make all of these recommendations
18 work, and should we address that issue as part of the
19 recommendation?

20 MR. WINTER: That's a very important question.
21 It's one we've raised in the challenges. You know this slide
22 here.

1 And it's something that CMS has raised in their
2 response to the GAO recommendation. They were concerned
3 about the -- they said it would involve significant
4 administrative resources.

5 MR. GEORGE MILLER: Yeah, yeah, and I wonder. In
6 your text, you did an excellent job of talking about a
7 decision support system. I don't know if this is possible,
8 but maybe as an alternative. An accountable care
9 organization or a large system, integrated system, has
10 decision support. I don't necessarily want to use the term
11 "exempt" them from it, but that may be a way to lessen the
12 burden because there would be something in place by the
13 private sector.

14 I don't know if we can incorporate that in our
15 discussion, but it's something we certainly think about and
16 look at, particularly in this budget-conscious environment
17 that all the federal government will be dealing with.

18 MR. HACKBARTH: This is a really big issue,
19 George, and thanks for underlining it.

20 This would be complex, and I don't know how CMS is
21 going to come out at the end of the appropriations wars that
22 are now underway on the Hill. But there's going to be a lot

1 of pressure, I would think, on their operational budget.
2 For sure, the things that they're being asked to do are
3 growing much more rapidly than the dollars are that they
4 have for their operations.

5 MR. WINTER: And just a second point regarding
6 exempting systems or providers that have decision support
7 software or a decision support system from prior
8 authorization, a couple -- there are examples in the private
9 sector where a couple of plans have allowed this to happen.
10 One case I talked about in the chapter, in the paper, which
11 is Massachusetts General. Another case is Health Partners
12 in Minnesota, and their medical director spoke to the
13 Commission in 2007 about their approach.

14 DR. MARK MILLER: Just to follow up on George's
15 question, just to parse through a few things. So we have
16 four recommendations we're talking about. Two and three are
17 not large administrative burdens for CMS, correct?

18 MR. WINTER: I think that's correct.

19 DR. MARK MILLER: Okay. The first one is sort of
20 asking the Secretary to investigate packaging, putting
21 things together in the midst of the same visit, or looking
22 at the accumulation. So that's more of a research, kind of

1 identification of opportunity type of thing. It probably
2 does have some administrative cost but perhaps not
3 prohibitive.

4 Then I think it's the prior auth where we get to
5 the real deal, and I think that's where your question
6 applies

7 MR. WINTER: And really, the first two draft
8 recommendations are building on directions that the agency
9 has already been moving in.

10 DR. BORMAN: Relative to Recommendation 1, I would
11 just say that I was on the CPT panel when the trend to
12 component coding, which is the multiple codes sort of that
13 in the end describe what some might consider a single
14 service really started to accelerate, and to some degree
15 that was payer driven by virtue of wanting to capture some
16 parts where someone might in fact perform an image-guided
17 service, but somebody else actually formally read out the
18 interpretation. It really reflected combinations of things
19 between say a surgeon sticking the liver while the
20 radiologist is doing some guidance, or some of those kinds
21 of things, and it was an attempt to capture the work of both
22 physicians. Also, there were some other reasons on some

1 other component coding.

2 So I do want to be clear. I think everybody
3 should be clear, that there were some good things about
4 component coding, and there were some desires by CMS and
5 other payers to have -- some of it did get out of hand
6 probably, so just to say that.

7 Glenn, in terms of -- or Ariel, you've got all the
8 answers today. You may have a prior slide. But on bullet
9 2, when we talk about multiple ambulatory services during an
10 episode of care, could that potentially mean multiple office
11 visits for the outpatient treatment of pneumonia?

12 MR. WINTER: Absolutely. Yeah. We tried to
13 phrase it very broadly.

14 DR. BORMAN: Okay. So it's not just trying to
15 target an imaging procedure, or whatever. Okay.

16 Then on slide 12, relative to Recommendation 2,
17 this is not limited either by the nature of the imaging
18 study. So this isn't meant to be just CT-head/neck/chest,
19 but potentially that if somebody had a vascular ultrasound
20 and then had an angiogram at the same time there would be ea
21 discounting. Is that correct?

22 That it would cross modalities and it would cross

1 body sites and thereby potentially diagnoses, is that
2 correct?

3 MR. WINTER: Right. The way it works now, until
4 recently it was limited to within modality and within body
5 site. CMS recently expanded it, as you may know, to cross
6 modalities and body regions. So now if you do a CT of the
7 pelvis and CT of the head, different regions, but it's in
8 the same session, the reduction to the technical component
9 applies.

10 So I would envision, and we can talk about this in
11 the text. I would envision the same policy applying if you
12 were to recommend a discount for the professional component,
13 but again that's up for your discussion.

14 DR. BORMAN: I do think when you cross modalities
15 there may be potentially a little bit of a concern, but
16 that's a relevant comment.

17 On page 15, my last question to you is in some
18 prior discussions, although not necessarily on this topic --
19 I think it was on the utilization, the equipment utilization
20 discussion -- we sort of looked at nuclear medicine, CT and
21 MRIs as advanced imaging because of their dollar cost,
22 somewhat differently than we looked at standard imaging and

1 echography. And so, now we're sort saying that kind of was
2 a distinction that's not useful for this conversation.

3 MR. WINTER: It depends on where you want to draw
4 the line. I mean we've tried to frame this draft
5 recommendation pretty broadly to apply to not only imaging
6 but all other kinds of diagnostic tests that have a
7 physician work component in the physician fee schedule. And
8 so, that's where we have started. That's where we're
9 starting off, but if you want to think about limiting it to
10 advanced imaging, that's something to talk about.

11 DR. BORMAN: I'm not necessarily being critical.
12 I just want to make sure I understand the nuances.

13 MR. WINTER: Right. This is meant to apply more
14 broadly.

15 DR. BORMAN: Thanks.

16 MR. HACKBARTH: Okay, round two comments. Since
17 we have draft recommendations, I would appreciate it if you
18 would give me some sense of whether you're for or against,
19 or could be for if X, Y and Z were changed.

20 DR. DEAN: I'm comfortable with the first three.
21 I do have some hesitation about the prior authorization.
22 Like Ron, I would wholeheartedly support prior notification,

1 and if in fact there's evidence that it can achieve a
2 similar kind of result, I think that would -- it evokes
3 certainly significantly less hostility because prior
4 authorization evokes a substantial amount of hostility. And
5 it's just a burden. It's just a hassle. You know. It's a
6 hassle all the way around.

7 The other problem with it is that there are some
8 conditions for which our guidelines are there's good
9 evidence base, they're well developed, they're reliable.
10 And in those, I think it makes sense.

11 There is a lot of what we do that's fairly gray,
12 and I think the guidelines are not nearly as well developed.
13 And there's also a concern that a guideline that applies to
14 a particular patient who has one condition may be very
15 different for an elderly patient that has four other
16 diagnoses. And believe me, we see a lot of those.

17 So I'm a lot more hesitant about the prior
18 authorization, both because of the resources that it
19 requires by all the participants as well as the sort of
20 science base we have to support it.

21 I would be actually more comfortable -- I suppose
22 it makes sense that it should be applied to the high users.

1 On the other hand, I would be almost more comfortable to
2 apply it to certain selected conditions where we really know
3 we have the evidence base to support it.

4 MR. HACKBARTH: Let me just emphasize if there's
5 something that you would like to see recommended that's not
6 even touched upon here, that's fair game too.

7 So, Cori.

8 MS. UCCELLO: I think 2 and 3 are no-brainers.

9 With respect to the third one and whether we're
10 talking about the physicians or the practices, I would be
11 comfortable using practices instead of physicians to prevent
12 gaming issues.

13 The first one I think makes sense.

14 The fourth one I'm concerned about the burdens. I
15 would be very comfortable with notification rather than
16 authorization, but just because -- I mean it almost seems
17 like prior authorization for everybody would be easier than
18 just having to identify the outliers. So either that or the
19 notification I think might make more sense than the outlier
20 issue.

21 MR. HACKBARTH: On Cori's first point about
22 practices versus physicians, my understanding is that we

1 don't always know the practice. Sometimes every individual
2 physician in the practice has their own number, and we can't
3 relate them to one another. And other times it's the
4 practice that has the number, and they're all using.

5 MR. WINTER: Right. So they should --

6 MR. HACKBARTH: We don't always know when people
7 are in the same practice, in short, right?

8 MR. WINTER: We don't always know. However, if
9 they share, each claim has a tax number on it, and the tax
10 number should relate to a common practice.

11 One exception is sometimes physicians, if they are
12 contracting for multiple practices, let's say, they can bill
13 under multiple tax numbers.

14 MR. HACKBARTH: I see.

15 MR. WINTER: So I think the way to do this is to
16 look at the tax number on the claim, and if the tax number
17 for the referring physician is the same number for the
18 ordering physician then you would assume the same practice.

19 I'll stop there. That's an important question.

20 MR. HACKBARTH: Okay. Scott.

21 MR. ARMSTRONG: So I think I am close but a
22 slightly different place. I would support all four

1 recommendations. I understand the concerns expressed, but
2 I'm much more comfortable with the idea of prior
3 authorization, particularly limiting it to high-volume
4 providers.

5 My discomfort comes, to the degree I have any,
6 from the fact that this is so out of context of so many
7 other things that I would want to complement prior
8 authorization with, like discussions about utilization
9 profiles and rates, and some kind of comparative reporting,
10 or any number of other ways in which there are proactive, or
11 -- other than reducing payment, there are a lot of other
12 ways of changing practice patterns, and we really don't
13 speak to that in these recommendations. One day I hope we
14 would be.

15 MS. BEHROOZI: [Inaudible] -- because of the
16 concerns expressed around prior authorization.

17 I do think that, as Cori said, you could just say
18 it applies to everything or to everyone ordering certain
19 types of tests. You know. There are different
20 configurations for targeting, as talked about before.

21 And it does just feel like a lot of the discussion
22 and analysis is around self-referral, and that kind of

1 lowers the thresholds a little bit maybe on how precise you
2 have to be about identifying what's an outlier in certain
3 other of those targets. So that might be a refinement that
4 makes it more palatable.

5 The other issue that we aren't addressing here,
6 maybe it's more relevant to some of the other areas besides
7 imaging, but the whole area of things that aren't done on
8 the same day. You know when you're talking about self-
9 referral, right, the things that are not for the immediate
10 diagnosis and things like that. So I wouldn't mind if we
11 said something about that too, but maybe that's one of the
12 prior authorization criteria then too.

13 DR. STUART: I support the first three
14 recommendations with one suggested change, and that is that
15 I don't see any reason why they should be budget neutral.
16 So I would favor not having language about whether they're
17 budget neutral. I would have language to the effect that
18 you expect to have some savings going back to the trust
19 funds

20 I too am a little ambivalent about prior
21 authorization, particularly in the light of CMS's own
22 ambivalence, or maybe opposition, to this tool. And one way

1 we might be able to approach this is through a
2 recommendation for pilot tests, so that some of these
3 questions that we've raised could actually be field-tested,
4 or a demonstration. I guess pilots would be the best since
5 if you find something then you can put it into play. So I
6 would just simply add that as a possible.

7 MS. HANSEN: I am fine about the first three.

8 The fourth one is related to a comment on the
9 previous presentation, that again it's assuming that the
10 physicians who are ordering a lot more imaging have somehow
11 been screened that these are beneficiaries who actually may
12 need a lot more imaging. So in other words, is there a
13 subgroup of looking at the appropriateness of it, or is it
14 just the comparison of a similar practice and they still are
15 outliers?

16 So it's one of the things of just distinguishing
17 this fourth recommendation a little bit more.

18 DR. BERENSON: I support 2 and 3.

19 I'll get to 4 in a second.

20 I find I'm a little bit unhappy that within
21 Recommendation 1 you've got 2 very different things that
22 you've put together. What Karen described earlier as

1 component coding and putting together services that are
2 always done at the same time into a logical comprehensive
3 code is straightforward. That should happen. It is
4 happening. The RUC and CPT are doing it. That is very
5 different from an ambulatory episode of care where you're
6 putting together a longitudinal care over time.

7 I am very skeptical about our ability to
8 operationalize ambulatory episodes. And this isn't the time
9 to do it, but I could tick off four or five design issues
10 that I think might disable the problem. So I think it's a
11 little too facile to just say let's go do it.

12 I'm all for the Secretary for studying it. I
13 think it's much tougher even than the hospital-based
14 episodes which at least are anchored in a hospital base.
15 I'll just give a couple of my concerns -- is episodes will
16 come out of the woodwork.

17 If we're going to pay for an episode of low back
18 pain, what was then an incidental thing that happened as
19 part of an office visit will now be an episode of low back
20 pain unless we had some way to protect against that.

21 We have to deal with the issue of does the episode
22 include the MRI for low back pain or does it not include the

1 MRI for low back pain, either penalizing or rewarding
2 somebody who has the equipment.

3 I just think there's a whole bunch of issues in
4 there. I'm happy to study it. I'm happy to develop it.
5 I'm skeptical that it becomes a solution.

6 So now I'm at 4. I'm for prior authorization in
7 this area. I would emphasize that it only -- it has to be
8 evidence-based, and so I share the concern that Tom raised,
9 that if we're in areas that we don't have good guidelines
10 and there is no evidence or consensus around the right care,
11 we've got to go light. So that's number one.

12 Number two is it absolutely has to include gold-
13 carding which is the term that private insurers use, which
14 is they should be limited to the 10 or 20 percent of
15 practices that abuse the privilege of self-referral or of
16 over-referring. We can't just have this as a routine
17 intrusion into every doctor's practice, which is the way
18 managed care did it, and I think right from the beginning
19 that should be a principle.

20 And then I want to finish with the following: I
21 am sympathetic to your view that, when done right, self-
22 referral is a desirable thing, but I participated in a

1 meeting last week where an administrator of a cardiology
2 practice with about 12 docs sort of made a presentation in
3 which he was demonstrating how bad a partner Medicare was
4 when Medicare had the temerity to reduce fees for nuclear
5 scanning and things, which will reduce their income by 40
6 percent was the assertion. CMS finds maybe 14 percent over
7 4 years. It means they're doing an awful lot of these
8 things or he was making it up.

9 Number two, he was talking about isn't it
10 unfortunate that we had to buy our own CT angiography
11 because we couldn't get together with the hospital and the
12 other cardiology group in town. So we are all now going to
13 do a lot too many of these because we couldn't get together.
14 It was real clear. He just right out front said it.

15 And then the shocker of this discussion was he
16 talked about CMS may have the nerve to reduce payment for
17 PET scans that they had recently purchased.

18 So we have a cardiac practice with that kind of
19 technology billing the hell out of Medicare, and so what I'm
20 going to suggest in addition to prior auth, which presumably
21 would catch this group, is the potential of civil monetary
22 penalties. Tomorrow, we will be recommending some

1 intermediate sanctions for poor quality. I don't know why
2 we wouldn't also tie that to the prior auth program where we
3 find real abuse of the program -- some kind of intermediary
4 sanctions with the ultimate threat of kicking somebody out
5 of the program.

6 What we've got here is echelon practices not
7 abusing self-referral and then people who are absolutely
8 abusing it and actually think Medicare is the bad partner
9 when in fact they're the bad partner. They're the ones
10 forcing us to have to recommend these kinds of policies,
11 which is unfortunate.

12 So I do -- I am sympathetic to not just banning.
13 You know. They have invested in their PET scan. So I don't
14 know what to do about them. But I would certainly want to
15 hold them to a standard that they're doing it appropriately,
16 which I think should be pretty rare, pretty rarely. And if
17 it turns out in prior auth that they are not following the
18 evidence-based guidance in that area, they shouldn't just
19 walk away scot-free in my view.

20 MR. WINTER: Could I just clarify your comments on
21 the prior authorization and the gold-carding?

22 DR. BERENSON: Yeah.

1 MR. WINTER: Is the notion that you would target
2 all self-referring physicians for all high utilizing
3 physicians.

4 DR. BERENSON: High utilizers. High utilizers. I
5 assume that many of them would be self-referring physicians.

6 MR. WINTER: Right.

7 DR. BERENSON: I suppose until you develop the
8 profiles you're probably reviewing everybody, but I would
9 very quickly sort of give a lot of people passes.

10 And the final thing I forgot to say is I actually
11 would start here. I think there are other places where
12 prior authorization has a role in the program. There's a
13 recent published article that didn't make our handouts,
14 about the overuse of insertions of intracardiac
15 defibrillators, far beyond clinical indications, far beyond
16 what CMS has approved as the coverage. It's a \$50,000
17 elective -- usually elective -- procedure. I think Mark has
18 heard me say this a lot. I think it's ripe for a prior
19 authorization program.

20 I think we could establish pretty strict criteria,
21 so that we're not applying prior authorization where we
22 don't have evidence, which is where it's not a high-cost

1 item, where there's no significant practice variation. But
2 when a service meets a set of strict criteria, I think CMS
3 should do it.

4 But I wouldn't start there today. I would start
5 with something that has some evidence of success with
6 private insurance, see how it works and then see if it can
7 be the model for building on for other very selective uses
8 of prior authorization.

9 MR. HACKBARTH: So could I ask you about Draft
10 Recommendation 1? I think your point that the two bullets
11 are fundamentally different is a good one, and I would also
12 agree that the second bullet raises some really complicated
13 issues.

14 So if we were -- on the other hand, I hear you
15 saying that the first bullet is already being done. Did I
16 interpret that?

17 DR. BERENSON: It's being done, but I don't have
18 any problems with taking credit for -- I mean it could be
19 done. I don't know if we need to.

20 I mean I don't know enough to know whether a
21 further nudge would be helpful or not. I know a lot of good
22 activity is going on this area.

1 MR. HACKBARTH: Okay. So the question I'm getting
2 is if we were to drop the second bullet because it's a whole
3 different kettle of fish, does it make sense to have a
4 recommendation with just the first bullet?

5 DR. MARK MILLER: If I could just parse through,
6 although given the passion that Bob was feeling there at the
7 moment I wasn't sure I wanted to go in. But I just want to
8 parse through your comments on the first thing, none of the
9 last stuff. You're okay there.

10 But the first thing, when you raised on bundling,
11 I just want to walk through a couple of levels. There is
12 the stuff that's going on. Okay? And that tends to be
13 procedure-oriented.

14 At least some of the next level would be packaging
15 other things -- office visits and tests, that type of thing,
16 asking CMS, the RUC to begin to think about packaging beyond
17 what their current efforts are.

18 A third level of bundling is bundling like the
19 global surgical fee where you say it's the same physician
20 doing a series of services over a set of time.

21 Then the next level of bundling -- I don't know
22 how many I have going at this point -- is the one where I

1 think you referred to more as the ambulatory episode where
2 it's multiple providers, multiple time.

3 And I'm just trying to narrow in. My sense was it
4 was the last one that gave you the most --

5 DR. BERENSON: Yeah. No, I think there are some
6 sort of operational issues. Even on a global payment now,
7 there's at least a suspicion that the payment for a 90-day
8 global period for surgeons has too many post-surgical days
9 because patients don't stay in the hospital anymore, that
10 they may be valued at too high an office visit level. Those
11 are technical issues, but I'm all for keeping 90-day global
12 payments.

13 I am very much talking about the episode over
14 time.

15 DR. MARK MILLER: So the reason I wanted to raise
16 this is if we're re-torque this I think there's still a
17 couple of packaging, bundling things --

18 DR. BERENSON: You know packaging. I think if
19 we're going to throw the urinalysis and something else in
20 with the office visit and get some efficiencies because
21 there's not duplicate work there you could either do it
22 through a package or similarly you could reduce the payment

1 for the second service. I think that's a reasonable area to
2 proceed. You're not sort of changing fundamentally changing
3 incentives for anybody. So I'm all for proceeding in that
4 area.

5 It is about the ambulatory episode of care that
6 gives me the --

7 DR. MARK MILLER: We'll give you something to
8 rework there.

9 MR. HACKBARTH: So help me with the language here.
10 So packaging is same provider, same visit, multiple services
11 provided by same provider, same visit.

12 We can use the term "global payment" for same
13 provider but multiple visits over time and then having a
14 single payment as in the surgical global payment. And what
15 I hear you saying is that there may be some opportunities
16 for global payment in that sense -- same provider, different
17 visits.

18 The area that Bob is most concerned about is
19 bundling different providers, different visits --

20 DR. BERENSON: No, even the same provider over a
21 long period of time, over an extended period of time.

22 And there are people who think we should go in

1 this direction. So I don't want to unilaterally sort of
2 dissuade. You know.

3 Prometheus I guess is the group that is developing
4 these ambulatory episodes. I think they have oversimplified
5 the operational issues, but I'd be talking to them.

6 And I'm all for exploring this area, but I think
7 there's a number of concerns, even with a single provider.
8 What an episode of back pain is in a patient with five
9 chronic conditions, are we going to be paying for an episode
10 of back pain, then an episode of hypertension, then an
11 episode of diabetes?

12 It's very non-holistic, and I think aimable. And
13 so, I do raise concerns, but there are people working in
14 this area, and I'd want to take advantage of their
15 expertise.

16 MR. HACKBARTH: Okay. Herb.

17 MR. KUHN: Generally supportive of all four
18 recommendations; 4, however, I'm like others. I've always
19 felt a little more comfortable if we had an outlier policy
20 or gold card policy or something like that where we aren't
21 engaging all physicians but really kind of recognizing the
22 outliers where we can be focused on.

1 DR. CASTELLANOS: I just have a couple questions
2 before we go with recommendations. The multiple procedure
3 payment thing, that applies to all settings -- a hospital,
4 the IDF and the office. Is that correct?

5 MR. WINTER: Yes.

6 DR. CASTELLANOS: Okay. So there's no --

7 MR. WINTER: That's Draft Recommendation 2.

8 DR. CASTELLANOS: Right. Okay. Like Bob, I'm
9 concerned about the bundled payments that include things
10 that are episodes of care. I think we need a lot more
11 discussion on that. So I'm for the first part but not for
12 the second part.

13 The second, again, my concern here is that I want
14 to make sure that this applies to all sites of service --
15 the office, the IDF and the hospital.

16 MR. WINTER: You're asking about the first bullet
17 on Draft Recommendation 1?

18 DR. CASTELLANOS: No, Draft Recommendation 2.

19 MR. WINTER: Okay. Yes, that's how we drafted it.

20 DR. CASTELLANOS: Okay. Now Draft Recommendation
21 3, as it was presented, it only applies to the office. Is
22 that correct?

1 MR. WINTER: Yes.

2 DR. CASTELLANOS: Okay. I'm against that. I
3 would certainly like to explore the possibility of extending
4 that, if feasible, into the hospital and to IDF.

5 MR. HACKBARTH: Ariel, are there issues in doing
6 that? Why is this one cast as only the office whereas 2 is
7 everywhere?

8 MR. WINTER: Right. The notion here is we're
9 trying to account for potential duplications of physician
10 work. And so, if the physician who is billing for the
11 professional component is the same one who ordered the
12 service and is presumably treating the patient, they
13 probably have already obtained information about the
14 patient's medical history and their symptoms and prior
15 tests, and those sorts of things.

16 If it's in the hospital context, you could perhaps
17 argue the same thing, that if the physician who ordered the
18 service is treating the patient on an ongoing basis, or at
19 least has enough information to make their job easier when
20 it comes to billing for, doing the professional component,
21 if we're still using imaging as an example. So you might
22 want to think about expanding it to those settings as well,

1 but it's something we can think about.

2 MR. HACKBARTH: Yeah.

3 DR. CASTELLANOS: Only because 40 percent of the
4 doctors are now employed, and it's going up each year. So I
5 think we need to consider that.

6 MR. HACKBARTH: Yeah, I think that's a good point.

7 DR. CASTELLANOS: To Recommendation 4, Bob, you
8 convinced me. When we have some of these guys that are
9 really outliers, we need to go after them. And I have no
10 problems with prior authorization for significant outliers.

11 DR. KANE: Well, after listening to all, I was
12 inclined to be fine for all four of them, but now that I've
13 heard all this conversation I think I certainly support 2
14 and 3. I agree with Ron that it should be applied to all
15 settings.

16 Just on 4, I guess isn't there something in the
17 Medicare original statute that says the government is not
18 supposed to tell doctors how to practice medicine, and
19 doesn't that get kind of close to that? Except, unless
20 you're going after fraud, in which case Bob's approach is
21 something I think is fine.

22 But is this getting into the government practicing

1 medicine? And how you avoid that, I don't that. That's
2 just a question.

3 But I think the prior notification and/or prior
4 authorization, certainly prior authorization for people who
5 are being abusive.

6 And I agree. I've heard similar conversations,
7 actually from both cardiology practices and the urology with
8 a gamma knife. They want to use the million-dollar gamma
9 knife. So they use it over and over and over again for
10 things that aren't really appropriate as well. So I mean
11 there's a lot of opportunity. It's not just in the imaging.

12 So anyway, maybe we need to establish a prior
13 authorization program for physicians who order substantially
14 more advanced imaging and possibly extend it to other
15 services as becomes apparent because I don't think it's just
16 limited to advanced imaging. When someone buys a million-
17 dollar fixed cost piece of equipment, they're going to use
18 it.

19 MR. HACKBARTH: Yeah. Well, I sort of like the
20 idea that Bob mentioned, that clearly this is a tool that
21 could be applied in a lot of different places, but maybe it
22 makes it sense to start narrow and then see if in fact we

1 can make it work through all of the complex administrative
2 issues and then talk about expanding it from there.

3 So as opposed to having it in the recommendation,
4 expand it across the board. Let's just have that in the
5 text as a possibility -

6 DR. KANE: Possibility.

7 MR. HACKBARTH: -- provided that we can --

8 DR. KANE: And then I'm going to let you worry
9 about the language for whether this is practicing medicine
10 or whether there's a fraud piece that you're preventing, and
11 just let you worry about that because I don't know the
12 answer.

13 MR. HACKBARTH: For many years, Medicare has
14 retroactively denied payment for services, and this is more
15 shifting the time of the decision as opposed to making a
16 fundamentally different sort of decision.

17 MR. WINTER: And at one point in the 1980s, CMS or
18 HCFA did apply -- develop prior authorization for certain
19 surgical procedures. This was mandated by Cobra. So
20 there's a specific statutory mandate, and it was done by the
21 PROs which are now called the QIOs, and it was eventually
22 dropped because the approval rate was very high.

1 DR. KANE: Yeah.

2 MR. BUTLER: Okay, on 4, I think your data in
3 here; it said 2 percent of the ordering physicians had 20
4 percent of the -- it would be a little more compelling that
5 you could say let's do prior authorization on 2 percent, and
6 you could even outsource it to an RBM and not have CMS be
7 even burdened with the administrative costs. I'd be very
8 supportive of that kind of approach.

9 I'm really lost now on Recommendation 3, on where
10 we're at, frankly. We started this whole exercise largely
11 because we were worried about physicians who owned their own
12 equipment and were over-utilizing it.

13 As I pointed out before, let's forget about the
14 hospital side now. If they have a radiologist reading an
15 image in their office, right now they're off the hook.
16 Right?

17 MR. WINTER: Right. Under this draft
18 recommendation, yes, because it's the same physician.

19 MR. BUTLER: Right. And frankly, if they don't
20 have a radiologist doing it now, they will if we put in this
21 place, and they'll just buy it on the margin, and we'll be -
22 - right. So that defeats that one.

1 So I think it has to apply to the practice, but
2 then I get lost on the hospital side. What the heck are we
3 -- then it just kind of applies to everybody. If you do it
4 to the whole practice in the office, now you've got to do it
5 to the whole practice in the hospital. So basically, it
6 applies to everyone, everywhere, and we're just reducing
7 fees regardless of ownership, referrals or anything. Right?

8 We just get a rate reduction, I think. Isn't that
9 what this in effect does?

10 DR. CASTELLANOS: Didn't you clarify that this is
11 the same physician that orders it and does it, and it's not
12 a part of a practice?

13 MR. BUTLER: And that's my problem. If you do it
14 with just the physicians that are both ordering it and doing
15 it, that will be gamed in a second, I believe.

16 DR. CASTELLANOS: You're probably right.

17 MR. BUTLER: It will be gamed. They'll say fine,
18 I'll order it, but I won't do it. I'll have the radiologist
19 read it.

20 You still get the technical component, you still
21 get all the money, and you still make almost as much as you
22 do now, and you don't have to do it yourself. That's what

1 will happen if we do this in the office.

2 So now if you bring in the hospital and you want
3 to bring -- and I understand if you bring a cardiology
4 practice. I'm not -- you know. I'm not quite sure we're on
5 the hospital side of this and how it would work without
6 basically saying all of this ought to be reduced in prices,
7 period. So somebody needs to think that through.

8 MR. HACKBARTH: Yeah, and I think you're raising
9 an important issue. We do need to think it through.

10 I'm not sure that if you're talking about an
11 office practice that everybody is going to go out and hire a
12 radiologist if they don't already have one in order to evade
13 this. However, if you extend it to the hospital, clearly
14 they'll get around it by saying oh, we'll just have the
15 radiologist read it and then split it up.

16 MR. BUTLER: They can outsource the reading though
17 and have it billed under that outsourced radiologist's name
18 for the professional component.

19 MR. HACKBARTH: Yeah.

20 MR. BUTLER: I think. That's what happens.

21 MR. WINTER: I would expect in most cases in a
22 hospital these are being billed by a radiologist

1 MR. HACKBARTH: I see your point.

2 MR. BUTLER: I'm not positive, but we just need to
3 think that through.

4 MR. HACKBARTH: Okay, in the interest of time.
5 You've made a good point. We'll think through that some
6 more. Let's keep moving, so we can get done.

7 DR. NAYLOR: So I support all the recommendations.
8 I would agree with Ron in terms of trying to think about
9 applying this Recommendation 3 across settings, with all the
10 caveats we just heard and Cori's recommendation with 3 about
11 looking at it not just as a same physician but physicians
12 within the same practice. I don't know what's possible, but
13 I think that that's important.

14 Bob's recommendation about 4 being evidence-based,
15 adding a penalty and Peter's suggesting increased clarity on
16 it, I think all make a lot of sense.

17 And Ariel, I just want to say that your
18 illustration raised a question for me which is: Is there a
19 potential here to have multiple images at one visit that
20 continue to add cost? I was just -- is that something that
21 all of these recommendations cover, or any of them cover?

22 MR. WINTER: Right. So there's already the

1 potential of financial incentive --

2 DR. NAYLOR: Say your head, your neck, your --

3 MR. WINTER: -- to do multiple imaging services.

4 DR. NAYLOR: Right.

5 MR. WINTER: And the intention behind the multiple
6 procedure reduction, which was based on our recommendation
7 in 2005, was to reduce the financial incentive, so that it's
8 only done when it's clinically appropriate and necessary.

9 DR. NAYLOR: Okay.

10 MR. WINTER: And so, what we're trying to do here
11 is apply that same logic to the professional component --

12 DR. NAYLOR: Okay.

13 MR. WINTER: -- and by accounting for
14 duplications, efficiencies, you know, reduce any additional
15 profit incentive that might be motivating multiple imaging
16 studies in the same session.

17 DR. NAYLOR: Great. Thank you.

18 DR. BAICKER: I support the recommendations.

19 I would definitely want Recommendation 4 to be
20 targeted towards high users because I have a suspicion that
21 it's that targeting that provides the real incentive, not
22 the actual review, that you don't want to be the guy who

1 suddenly falls into the category of having to do all the
2 prior authorization. In this instance, unlike Karen's
3 important point about keeping hassle costs in mind, this
4 seems like a case where hassle costs are good because you
5 want people to avoid being in that group. So that targeting
6 seems important.

7 And as for Peter's point which I think is, first
8 order, thinking about people would respond to it, I also
9 would want to be sure that we understood how offices were
10 designated in that I can certainly imagine if you're just
11 looking at the same taxpayer ID does it change your
12 incorporation strategy, where you don't change anything real
13 in the office but suddenly you're two independent
14 contractors, or something. I don't know what the legal
15 structures are, but I would imagine if they're small changes
16 people can make to get big changes, or even small plus
17 epsilon changes in reimbursement, they would do that.

18 MR. GEORGE MILLER: Yes, I'm going to give mine,
19 and Karen asked me to take hers also although she would have
20 benefitted from Bob's comments.

21 So first, Karen said on 1 she's okay, but she had
22 concerns, and Bob covered that. And 2, she's okay maybe but

1 needs to think about it. On 3, she was okay. And she had
2 concerns about 4 for all the reasons that were discussed.

3 And for me, it's just about the same although I
4 like Bob's comment about the gold-carding or having, for 4,
5 it be defined that we're dealing with those who are
6 outliers, and either a gold card would solve that problem.

7 MR. HACKBARTH: Thanks, Ariel.

8 And now we'll have our public comment period. Let
9 me go to the microphone, and let me quickly review the
10 ground rules before you begin. Please begin by introducing
11 yourself and your organization, and when this red light
12 comes back on that means your time is up. You'll have two
13 minutes for your comments.

14 And as always, let me remind people that this is
15 not your only or even your best opportunity to provide input
16 on the Commission's work. The other opportunities are
17 direct contact with the staff or to use our website, where
18 you can present longer than two minute comments.

19 MS. ROWE: Thank you. Can you hear me? I am
20 Elizabeth Rowe representing the Mid-America Neuroscience
21 Institute in Lenexa, Kansas.

22 Hospitals spend about 50 percent of the health

1 care dollar, whereas outpatient MRI imaging accounts for 0.5
2 percent, and as you pointed out, less than ten percent of
3 that is self-referred. Hospitals are rapidly buying private
4 primary care practices and thus completely capturing those
5 physicians' referrals to their hospital-owned services and
6 facilities, circumventing completely the prohibition on
7 hospital payments to private physicians for their referrals.
8 Hospital imaging centers are paid up to three times more
9 than freestanding outpatient centers for MRIs.

10 Hospitals have exclusive contracts with physicians
11 and physician groups, for example, radiology groups. Many
12 neurologists have special training and certification in
13 neuroimaging, but they are excluded from interpretation of
14 hospital MRI studies on their patients. This exclusionary
15 situation has motivated neurologists to own facilities. A
16 similar case occurs for cardiologists, orthopods, and other
17 specialties, as well as family practice groups. These
18 freestanding, lower-cost facilities provide competition for
19 the high-cost in-hospital facilities, thus lower costs and
20 increasing quality.

21 Recent studies post-Stark, unlike some of the
22 older studies, show that the so-called self-referral for MRI

1 by treating physicians does not lead to overutilization. I
2 can provide references to the staff. Self-referral that is
3 not regulated by Stark includes the self-referral of
4 radiologists when their reports suggest further imaging and
5 the self-referral of hospitals, as has been mentioned,
6 requiring their own physicians to refer to their own
7 facilities.

8 MedPAC is concerned about overall health care
9 costs. The accelerating shift of physicians from private
10 practice to hospital employment will increase overall costs
11 for the reasons outlined above.

12 In conclusion, I would urge the MedPAC
13 Commissioners to seek ways to support and even incentive
14 these lower-cost freestanding outpatient facilities owned by
15 physicians who take care of patients. I submit that this
16 would contribute much more to cost savings than any of these
17 options discussed today, which will only drive more
18 outpatient services into the high-cost hospital environment.

19 Thank you very much.

20 MR. ADLER: Hi. I'm Dave Adler with the American
21 Society for Radiation Oncology and I'm speaking today on
22 behalf of a coalition called the Alliance for Integrity in

1 Medicare. We're a coalition of professional societies and
2 health professional -- and groups representing other health
3 professionals that are united about our concerns of abuse
4 under the in-office ancillary services exception and a
5 solution for that problem.

6 I think our concern in listening to the discussion
7 today is that the solutions proposed do not get at the root
8 of the problem, which is the loophole in the self-referral
9 law, the exception for radiation therapy, physical therapy,
10 pathology, and advanced diagnostic imaging.

11 I think we are seeing increasing data that what's
12 happening out there, and Dr. Berenson, you're passionate in
13 talking about it, I'm just -- from our perspective, I think
14 it's pretty easy to say and pretty easy to see how these
15 solutions could be gamed and, I think, will be gamed. Once
16 you've made the investment in a linear accelerator, in an
17 expensive CT, you're going to find a way around these things
18 or you're going to up the volume to respond to the payment
19 cuts, and I just -- I think we'll just keep dealing with
20 these issues until we actually get at the root of the
21 problem.

22 And as far as the very important point about the

1 multi-specialty practices that really are true models of
2 health care delivery and we don't want to impact that, I
3 think there is a way, and we've been working on it through
4 our coalition, to make sure that those models aren't
5 interrupted and, in fact, maybe to encourage more physicians
6 to participate in such models. So we, of course, would love
7 to work with MedPAC on that.

8 Thank you.

9 MR. COONEY: Good evening. My name is Patrick
10 Cooney and I'm here representing the 77,000 members of the
11 American Physical Therapy Association.

12 First of all, I just wanted to thank you for your
13 work in this area and particularly your report from last
14 year. I think physical therapists have felt that this area
15 was a problem for many years, but I think your report last
16 year really spotlighted the concern very well.

17 Specifically, I think our concern is that the in-
18 office ancillary care exception does not represent -- or
19 what it was intended to represent were those services that
20 were integral to the patient's diagnosis on the visit to the
21 physician's office. When you look at some of the services
22 mentioned, including physical therapy, they're not integral

1 to the patient diagnosis and so their relevance to being
2 provided in the physician office, I think, is questionable.

3 As we look at, for example, physical therapy, from
4 your own report, you highlighted that only three percent of
5 the physical therapy services were provided on the same day.
6 And then two weeks later, still only less than 15 percent of
7 the services were being provided for physical therapy in
8 those offices.

9 We would urge you, in addition to the
10 recommendations that you've made here that I thought were
11 very thoughtful, we would urge you to also consider the
12 potential that was in your original report to look at
13 exempting out of the in-office ancillary care exception
14 those services that are not integral to the patient
15 diagnosis, as were mentioned by my colleague previously.

16 Again, we look forward to working with you on this
17 because we want to make sure that those settings that are
18 looking at the ACO models or that are looking at integrated
19 care are not impacted negatively by this. But we do think
20 that exempting out these services from the in-office
21 ancillary care exception would be a good step forward, so
22 thank you.

1 MS. McILRATH: Sharon McIlrath with the American
2 Medical Association. Just one point. No matter what you do
3 with the recommendations, this discussion about whether or
4 not they should be budget neutral, the Commission and many
5 policy makers have had a lot of discussions about the need
6 to redistribute money within the Physician Fee Schedule. If
7 you simply take the money that you got from these savings,
8 and particularly if you take the money that would flow from
9 the things that the RUC has done, and you don't redistribute
10 it, you use it for government savings, A, I think it's
11 somewhat hypocritical, and B, I think it will be harder to
12 get the RUC to put in the enormous amount of effort that is
13 involved in combining these codes and redoing surveys and
14 actually coming up with real numbers that physicians think
15 are fair if it's only going to be diverted from a system
16 that has been starved for the last nine years anyway.

17 MR. HACKBARTH: Okay. Thank you.

18 We will adjourn for now and reconvene at 9:00 a.m.
19 tomorrow.

20 [Whereupon, at 6:20 p.m., the meeting was
21 recessed, to reconvene at 9:00 a.m. on Thursday, February
22 24, 2011.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, February 24, 2011
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
PETER W. BUTLER, MHSA
RONALD D. CASTELLANOS, MD
THOMAS M. DEAN, MD
JENNIE CHIN HANSEN, RN, MSN, FAAN
NANCY M. KANE, DBA
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

AGENDA	PAGE
Care coordination for dual-eligible beneficiaries: evaluating special needs plans' models of care - Christine Aguiar, Carol Carter, Kelly Miller	3
Medicare's role in motivating and supporting quality improvement - Anne Mutti	55
Public comment	133

1 P R O C E E D I N G S [9:00 a.m.]

2 MR. HACKBARTH: Okay, good morning. We have two
3 sessions this morning, the first on Care Coordination for
4 Dual Eligible Beneficiaries, and then the second on QIOs or
5 Medicare's role in supporting quality improvement, which
6 includes QIOs, followed by our public comment period. We
7 will finish on time today, unlike yesterday, I promise that.

8 So beginning with duals, Carol, are you going
9 first?

10 DR. CARTER: No, Christine's going first.

11 MR. HACKBARTH: Christine is going first. Okay.

12 MS. AGUIAR: Good morning. During this
13 presentation, we will discuss the results of an evaluation
14 of the models of care submitted to CMS by dual eligible
15 special needs plans, also referred to as D-SNPs. This
16 analysis is part of our ongoing work considering how to
17 improve care coordination for dual eligible beneficiaries.

18 The Commission has been focusing on the dual
19 eligible beneficiaries because many of these individuals are
20 frail, disabled, or have multiple chronic conditions. These
21 beneficiaries qualify for both Medicare and Medicaid
22 benefits, and the care is often uncoordinated and costly.

1 In November, we discussed the results of our site
2 visits and interviews with stakeholders about programs that
3 integrate the care for these beneficiaries. We learned that
4 the programs vary considerably in their design. However, we
5 found similarities across programs on care coordination
6 activities and integration with Medicaid benefits.

7 For this analysis we are discussing today, we
8 compared the D-SNPs care coordination activities to those of
9 the integrated care programs that we discussed in November.
10 We conducted this analysis because we were interested in
11 assessing whether D-SNP care coordination and Medicaid
12 integration activities could be evaluated through the models
13 of care.

14 We also tried to assess whether there was a
15 relationship between the model of care descriptions and D-
16 SNP quality results. Kelly will now discuss key
17 characteristics of SNPs and our methodological framework.

18 MS. KELLY MILLER: SNPs are Medicare Advantage
19 plans that target enrollment to specific groups of
20 beneficiaries. These SNPs target enrollment to
21 beneficiaries who are eligible for both Medicare and
22 Medicaid. SNPs function essentially like, and are paid the

1 same as, any other MA plan. Unlike other MA plans, however,
2 they can limit their enrollment to their targeted
3 populations. Additionally, D-SNPs can enroll all
4 beneficiaries each month, unlike other MA plans that can
5 enroll beneficiaries only during specific periods.

6 Since their creation, there have been recurring
7 concerns about SNPs. The first, that SNPs are not
8 accountable to provide specialized care for their target
9 populations applies to all SNPs, including D-SNPs. The
10 second concern, that SNPs are not coordinating Medicaid
11 benefits applies only to D-SNPs.

12 To address the first of these concerns, that SNPs
13 are not held accountable for providing specialized care, the
14 Commission recommended that the Secretary establish
15 performance measures tailored for the SNPs, evaluate SNPs on
16 the performance measures, and make the information available
17 to beneficiaries and their counselors.

18 In an effort to make SNPs more accountable, CMS
19 required SNPs to report on three types of quality
20 information listed in the top row of the table. As shown in
21 the first column, SNPs now report 15 health care
22 effectiveness data and information set, or HEDIS measures.

1 HEDIS measures are clinical process measures such as
2 glaucoma screening, controlling high blood pressure, and
3 persistence of beta blocker treatment after a heart attack.

4 Most of these 15 measures were chosen from the
5 HEDIS measures all MA plans must report at the contract
6 level, though NCQA has developed three measures that are SNP
7 only. SNPs are also required to report structure and
8 process measures developed by NCQA, shown in the second
9 column.

10 These include things like complex case management,
11 care transitions, and coordination of Medicare and Medicaid
12 coverage. Plans are required to begin submitting these two
13 measures in 2009. SNP performance on these measures has not
14 been published.

15 Last, SNPs are also required to submit an
16 evidence-based model of care. CMS identified 11 elements
17 for SNPs to describe in their models of care. These include
18 assessing patient risk, developing an individualized care
19 plan, maintaining a centralized information system, and
20 having an interdisciplinary care team.

21 Only new and expanding plans in 2010 were required
22 to submit their models of care to CMS as part of the MA

1 application process. All SNPs must submit their models of
2 care to CMS by 2012. The models of care will also be used
3 in the SNP approval process. PPACA requires all SNPs to be
4 approved by NCQA by 2012.

5 In this year's proposed rules, CMS outlined a
6 potential approval process in which NCQA would review and
7 score the models of care. CMS is developing a scoring
8 methodology for NCQA to use. Plans with good scores may be
9 allowed to submit their models of care less frequently than
10 plans with lower scores.

11 The second concern is that SNPs are not
12 coordinating Medicaid benefits. The Commission expressed
13 this concern in 2008 when it recommended that the Congress
14 require dual eligible SNPs to contract with states in their
15 service areas to coordinate Medicaid benefits. D-SNPs must
16 have contracts with states by December 31st, 2012.

17 We wanted to evaluate whether the SNPs were
18 coordinating care for dual eligible beneficiaries, so CMS
19 shared with us the models of care that new or expanding SNPs
20 had submitted to them. We did not receive a model of care
21 for every SNP because existing SNPs that were not expanding
22 were not required to submit them.

1 Many SNPs with distinct contract numbers have the
2 same parent company, such as a parent company having SNPs in
3 multiple states, and the same model of care was submitted
4 for all of their dual eligible SNPs. In addition, some of
5 the plans submitted the same model of care for all their
6 SNPs, chronic, dual eligible, and institutional.

7 We received about 140 models of care in total from
8 CMS. After removing those models of care for chronic or
9 institutional SNPs, as well as the duplicate models of care,
10 there are about 40 distinct dual eligible models of care.

11 To analyze the models of care we developed an
12 analytic framework based on our research on the key elements
13 of care coordination. These key elements are SNP target
14 population, risk assessment process, care during
15 transitions, medication reconciliation, patient education,
16 utilization management, and coordination with Medicaid
17 benefits.

18 We reviewed the D-SNP models of care looking for
19 elements of these key -- evidence of these key elements.
20 After reviewing the models of care, we tried to compare the
21 descriptions with SNP quality data. We wanted to see
22 whether the quality of the descriptions was related to

1 quality measures. We looked at three data sources for
2 quality scores, star ratings, SNP-specific HEDIS measures,
3 and structure and process measures.

4 Now Christine will discuss the findings of our
5 analysis.

6 MS. AGUIAR: In general, we found that important
7 information on care coordination and Medicaid integration is
8 missing from the D-SNP models of care. D-SNPs are not
9 required to report about many of the key care coordination
10 activities of integrated care programs, or about
11 coordination with Medicaid benefits.

12 In addition, most of the model of care
13 descriptions were too general to evaluate their care
14 coordination activities. One limitation is a lack of
15 description about the D-SNPs enrolled population. Most
16 models of care state that SNPs enroll all duals or full
17 duals, but they do not describe the characteristics of the
18 beneficiaries, such as how many are disabled, have dementia,
19 or are frail.

20 As a result, it was often not possible to assess
21 whether a model of care was appropriately tailored to the
22 enrolled population. In addition, a few plans submitted the

1 same model of care for multiple types of SNPs, questioning
2 whether the models of care for those plans are, in fact,
3 tailored to meet the distinct needs of the different SNP
4 populations.

5 Of the care coordination activities conducted by
6 integrated care programs that we have included in our
7 analytic framework, the majority of D-SNPs only described
8 the risk assessment process. This activity, listed on the
9 left side of this table, is included in one of the sections
10 on the model of care.

11 The majority of the models of care include very
12 little discussion of the other key care coordination
13 activities in our framework, which are listed in the column
14 on the right. These activities include care coordination,
15 medication reconciliation, patient education, and real time
16 utilization management.

17 These activities are not questions on the model of
18 care and were generally not mentioned or were only vaguely
19 described. Only a handful of D-SNPs included clear
20 descriptions of these care coordination activities and we
21 will see an example of one of these descriptions on the next
22 slide.

1 The table on this slide includes an example of a
2 better D-SNP model of care description on care transitions
3 and patient education. This model of care describes the
4 role of the case manager during care transitions. The case
5 manager is responsible for assuring that information is sent
6 to the receiving institution, ensuring that members
7 understand discharge orders, and have access to medications
8 and services, investigating adverse events, and providing
9 feedback to providers and institutions.

10 The SNP also describes how patient education
11 varies by risk level. High risk members receive a review of
12 the current treatment plan and calls from a nurse health
13 coach to discuss the member's goals, while low risk members
14 receive ongoing health education and the opportunity to
15 contact a nurse health coach.

16 Another limitation of the models of care is that
17 D-SNPs are not required to report on their coordination with
18 Medicaid and the majority of plans do not discuss which, if
19 any, Medicaid benefits are covered by the plan or how the
20 SNP coordinates with Medicaid benefits.

21 For the few plans that did mention coordinating
22 with Medicaid, the descriptions tended to be vague. In

1 addition, most of the D-SNP models of care also do not
2 specify whether the SNP has a contract with the state, and
3 if so, what the contract covers.

4 The lack of reporting on Medicaid coordination
5 does not appear to be related to whether a D-SNP has a
6 contract with a state or is fully integrated. For example,
7 one D-SNP that was also a Medicaid managed care plan did not
8 describe the coordination with Medicaid benefits, even
9 though the plan's patient questionnaire implies that the
10 health plan does coordinate Medicaid benefits.

11 Although the majority of D-SNPs do not describe
12 coordination with Medicaid, there were a few exceptions and
13 we will see an example of one on the next slide.

14 This slide is an example of a D-SNP model of care
15 where Medicaid coordination activities such as finding
16 providers that accept Medicaid and coordinating Medicaid
17 services are described. This SNP maintains a registry of
18 social services organizations, directs members to community
19 services, tracks enrollees' Medicaid eligibility, and gives
20 enrollees a directory of providers who accept both Medicare
21 and Medicaid.

22 This information is helpful in understanding how a

1 SNP assists dual eligible beneficiaries access their
2 Medicaid benefits. However, only a handful of D-SNPs
3 included descriptions as detailed as this example.

4 Now I will move on to the results of our quality
5 data analysis. Our analysis of whether dual SNPs with
6 stronger model of care descriptions performed better on
7 quality measures, was limited by a lack of publicly
8 available quality data for SNPs.

9 For star ratings, the majority of SNPs do not have
10 their own star ratings because this information is included
11 in the overall reporting for the parent company, which
12 includes data on all of a parent company's MA plans and
13 SNPs. For HEDIS measures, we were missing measures for most
14 of the SNPs we had models of care for because the models of
15 care were submitted only by new or expanding plans, and
16 these SNPs were generally not in operation in 2008 when the
17 HEDIS measures were published.

18 We also found the published HEDIS subset data to
19 be hard to use because there's not a composite measure
20 reflecting the combined performance across all measures, and
21 many of the HEDIS results are blank because SNP samples
22 sizes were too small for measures to be calculated.

1 Finally, although CMS receives the SNP structure
2 and process measures, they're not publicly available.
3 Therefore, we were not able to review this data. Based on
4 our review of the D-SNP models of care, we have concluded
5 that the model of care descriptions cannot be used to
6 adequately evaluate care coordination for dual eligible
7 beneficiaries or coordination with Medicaid services.

8 It appears to us that D-SNPs need to be evaluated
9 on a complete set of care coordination measures, including
10 Medicaid coordination, in order to determine whether D-SNPs
11 are providing appropriate and special benefits to their
12 target population.

13 In addition, we feel that this information should
14 be collected from D-SNPs in a streamlined process that
15 reduces the reporting burden on the plans and the
16 administrative review burden on CMS. In addition, publicly
17 reporting SNP-specific quality data could help dual eligible
18 beneficiaries to make informed decisions when choosing a
19 SNP. This data could also be used to evaluate and compare
20 the quality of care of SNPs and to identify areas for
21 improvements.

22 For today's discussion, we would appreciate your

1 feedback on these two questions: Should D-SNPs be evaluated
2 on the care coordination elements in our framework,
3 including coordination with Medicaid, and are there key
4 elements missing from our framework?

5 We also wanted to make you aware that we are
6 preparing a chapter for the June report. The chapter will
7 cover the information we presented in November on our
8 findings from the site visits and interviews with integrated
9 care programs. The chapter will also include the findings
10 from our evaluation of D-SNP models of care.

11 This concludes the presentation and we welcome
12 your questions.

13 MR. HACKBARTH: Okay, thank you. Tom, we'll begin
14 with you, clarifying questions. Cori? Scott? Mitra?
15 Bruce?

16 DR. STUART: There's a lot to be concerned about
17 here. My question is, can you help us put this into context
18 in terms of what this market looks like? Specifically, you
19 talked about the fact that there were no separate reports
20 for individual SNPs that happened to be part of a larger
21 company. So how many entities are actually in this and then
22 how many individual SNPs are part of these entities? Is

1 this all for-profit business? Is there a non-profit
2 segment?

3 MS. AGUIAR: So these were as of January 2011.
4 There were 298 dual eligible SNPs. I believe most of those
5 are for-profit. We're not sure. We're actually not quite
6 sure of the number of -- how many of those are unique SNPs
7 and then not part of parent companies, but I believe that
8 the majority is part of parent companies. So there are more
9 SNPs that are part of a larger parent company than there are
10 SNPs that are just SNPs.

11 DR. STUART: That's what I anticipated. It would
12 useful to have that number so that we could see how many
13 organizations are actually responsible for making these
14 decisions, and we assume that it's the parent that's the one
15 that's driving it.

16 MS. HANSEN: Thank you. You know, if this of
17 great interest historically for me, and I think the chapter
18 really outlines a lot. It seems like a lot of activity,
19 actually, has occurred in the past probably a year and a
20 half.

21 One of the questions -- it's interesting that one
22 of the SNPs described from the parent company when the

1 application was made, the same application of conditions of
2 participation were given regardless of what segment of SNP
3 it was, so whether it's institutional, whether it's dual, or
4 chronic conditions.

5 Do you know if that's just from the CMS side that
6 that's something that they have changed so that they are
7 expecting more specific criteria for these three different
8 domains?

9 MS. AGUIAR: So one thing that I believe we did
10 mention in the presentation is that now SNPs per PPACA have
11 to be approved by NCQA, and CMS has decided that the model
12 of care is going to be the instrument for that approval.
13 From our conversations with CMS, they are -- that's an
14 evolving instrument, and I believe their intention is to
15 have some differentiation in the models of care between the
16 D-SNPs and the chronic SNPs and the I-SNPs.

17 MS. HANSEN: Great. And then since I know
18 probably the majority of the SNPs are dealing with an older
19 population, I noticed that, of course, there is a dual
20 eligible disabled population. Were there any particular
21 SNPs that you uncovered that had some particular data or
22 description on that segment?

1 MS. AGUIAR: I think that there was one, but one
2 of the problems, which was basically one of our first
3 limitations, is that the populations were not described in
4 such detail, so they would say full duals or all duals. So
5 they could actually really be enrolling a subset, a dual SNP
6 subset, which could be the disabled, but we just weren't
7 able to tell. But I believe Kelly reviewed -- is that right
8 -- one SNP that was specific to the under-65. Carol didn't
9 have any either.

10 MS. KELLY MILLER: I think there was one.

11 MS. HANSEN: There was one. I just think that
12 that's going to be another interesting one just because that
13 population will continue to grow, you know, the disabled
14 population will age-in and so therefore, there will be a
15 greater need.

16 I also noticed in the chapter that one of the
17 descriptors on one of the plans, they had a cultural
18 component to it, but is that anything else that you know is
19 moving in that direction to describe that? I know in
20 California, many of the SNPs are located in very racially
21 non-English speaking populations.

22 DR. CARTER: One of the things that CMS requires

1 plans that are submitting their application to be an MA
2 plan, since SNPs, all of SNPs are MA plans, so they submit
3 an MA application. As part of that, there's an attestation,
4 a series of questions about their --

5 MS. HANSEN: Right.

6 DR. CARTER: -- models of care and there are about
7 250 questions. One of the questions in there is about, do
8 they perform a cultural assessment of a patient.

9 MS. HANSEN: So this is up then NCQA to consider
10 whether or not this might be one of the things that they'll
11 look at in the future?

12 DR. CARTER: Right now NCQA, for their approval
13 process, is going to be approving the models of care and the
14 cultural assessment is not part of that.

15 MS. HANSEN: Okay, thank you.

16 MR. HACKBARTH: Questions, Bob?

17 DR. BERENSON: Yeah. I want to follow-up on this
18 issue of why the models of care were sort of so general and
19 not specific. Carol, you just mentioned that there's 250
20 questions that they ask, and yet, there's a vagueness? I'm
21 sort of confused as to --

22 MS. AGUIAR: Right, right.

1 DR. BERENSON: -- where the problem is here.

2 MS. AGUIAR: So there are two documents. There's
3 the model of care descriptions, which is what we reviewed,
4 and on this slide, we have the elements of -- there's a
5 model of care matrix, so this slide are the elements that
6 they have to include on the model of care and they'll just
7 go through some measurable goals, staff structure, structure
8 of care management, interdisciplinary care team.

9 Then as well as part of the application process,
10 there's this model of care attestation, which does have
11 these 250 questions. It's a yes, no attestation. So from
12 our conversations with CMS, we understand that the model of
13 care attestation will not be part of the NCQA approval
14 process. Rather, it will be the models of care descriptions
15 that CMS is developing a grading mechanism for, which they
16 discussed a little bit in the proposed rule. But the final
17 rule is not out yet, and so we don't know what the exact
18 grading system of that will be just yet.

19 DR. BERENSON: So the models of care request is
20 going to be much more precise about what is going to be
21 required as opposed to just having some categories and tell
22 us some information about it?

1 MS. AGUIAR: The model of care -- we haven't seen
2 it yet so what we're anticipating that it will be will
3 describe how the grading system will work. CMS has also
4 done a number of user calls with some of the SNPs to try to
5 give more guidance on the specificity of -- sort of what
6 they're looking for.

7 As we said, we found that some of the descriptions
8 to be rather general, so CMS is in the process of giving the
9 feedback to the SNPs about the type of information that they
10 want to see in the models of care. But the models of care
11 will remain a descriptive document that then CMS is
12 developing a grading mechanism for.

13 DR. BERENSON: So CMS agrees that what has come
14 back is insufficient for their monitoring -- for program
15 monitoring?

16 MS. AGUIAR: We did not outright ask them that and
17 they have not shared their opinion on that with us.

18 DR. BERENSON: Okay.

19 DR. MARK MILLER: I think both of you are starting
20 to zero in on at least part of the issue here. So you have
21 this application. You have these models of care. The hope
22 was that the models of care were going to actually describe

1 in some detail what was going on, and perhaps even could be
2 used for our input to get ideas from and from the purposes
3 of sort of looking at the program, whether programs could be
4 evaluated on that basis.

5 Maybe we've just been sort of polite in our
6 delivery here. The models of care have come back. They
7 don't seem to be very useful, and I think the question on
8 the table is if we want this information, is this the right
9 instrument, or should we ask for it differently or as part
10 of another instrument. And if we're going to continue to
11 use this instrument for this, then I think there's probably
12 a lot of change that has to go in place to make them useful.

13 DR. BERENSON: So at this point, we don't know
14 whether the models of care are inadequate or whether the
15 descriptions of the models of care are inadequate.

16 DR. MARK MILLER: Exactly.

17 MR. HACKBARTH: Yeah. Just to build on Bob's
18 point, so you could have models of care that are inherently
19 inadequate, they're not well-designed, and even if carried
20 out they wouldn't work. You could have models that are
21 fine, but people just are not sufficiently attentive in
22 submitting the descriptions.

1 Or you could still have another disconnect. You
2 could have great descriptions, good models, but they don't
3 reflect what happens in the real world. And we don't know
4 at this point which of those disconnects, if any, is the
5 problem.

6 MS. AGUIAR: Right. And I would completely agree
7 with that. Now, when we set out, we didn't know what the
8 state of the model of care descriptions would be, and so we
9 were really looking at this as can we evaluate them, compare
10 their actual activities to these integrated care programs.
11 We found we weren't able to do with that because that
12 information wasn't in there. And then information that was
13 in there was really general and vague, and so -- on the
14 whole, not in every single instance.

15 And so, we weren't able even to conduct our
16 original evaluation. I think when we step back to look at
17 okay, now, why was this, we saw, well, a lot of what we were
18 looking for were just not actual questions on the model of
19 care elements themselves, so they weren't required to talk
20 about coordination with Medicaid benefits.

21 We were sort of like, well, it's not surprising
22 that you wouldn't see that information there because on one

1 hand, they're not required to report on that, and then the
2 issue of the information that is there, you know, the
3 usefulness of it, since it tends to be so general and vague,
4 is something that CMS is in the process, I think, of
5 addressing through these user calls, or is hoping to
6 improve, again, through this grading process.

7 DR. CARTER: But it is why we then started to look
8 at the quality measures, because we were thinking, well,
9 what you have poorer descriptions, but actually all of the
10 models of care that they're actually using on the street are
11 fine and they are coordinating care and everything is good.
12 Then we realize, actually, there's not the quality data to
13 do that. So we're trying to tie that up.

14 DR. MARK MILLER: [Off microphone] - you want to
15 stay on time, it's just -- so there's a lot of activity here
16 on the part of the plan and on the part of CMS reviewing
17 this, and then eventually it's supposed to be kicked over to
18 NCQA, and I think one question is, is this a good use of
19 energy or is there a more streamlined way or a better
20 instrument to get all of this. This is not where we started
21 off, but this is where it's starting to take us.

22 MR. HACKBARTH: Herb, clarifying questions? Ron?

1 Nancy?

2 DR. KANE: On Page 6, I guess I'm just wondering
3 why -- so NCQA has not produced any HEDIS since 2008 and
4 they haven't brought the structure and process measures -- I
5 don't know if they've collected them, but just not shared
6 them or sent them? I mean, I guess, are we just looking at
7 this in a state of formative development or are we looking
8 at this in a state of this is what it's going to be unless
9 someone says something? Why hasn't NCQA done their piece?
10 I can't tell if this is just because it's in a state of
11 development or that people just don't think it's important
12 and it's not going to ever get developed.

13 MS. AGUIAR: Right. I think I get what the
14 question is asking. So NCQA does have the structure and
15 process measures and I believe since 2009 SNPs have been
16 reporting on them. There was a little bit of a phase-in so
17 not all SNPs had to report on all at the same time. But now
18 I think they actually are close to fully phased in, if not
19 fully phased in. So that's already ongoing and CMS does get
20 that data.

21 We did hear from CMS that they have reviewed that
22 data, but it's just not publicly reported yet for reasons

1 which I don't think we are completely -- we don't really
2 know why, or if they have the intention to report that data
3 soon. But that process is already ongoing and is underway.

4 DR. KANE: So the concern -- the models of care
5 data you collected you looked at and it doesn't look very
6 good. The other two we don't quite know where the --
7 whether that's about to be reported or has NCQA stopped
8 doing the HEDIS?

9 MS. AGUIAR: No.

10 DR. KANE: So the first two columns, the quality
11 measures, what do we want to say about that? You know,
12 hurry up or let us know when you get it? I'm a little -- I
13 hear what you're saying as to why you look at the quality
14 data. It was the models of care was too vague. But is
15 there anything we need to say about the speed with which the
16 quality matrix are being reporting or published?

17 MS. AGUIAR: I think we could, but I think the
18 comments would go to CMS, not NCQA. I think NCQA has been
19 collecting these data. They did it in phases. They've been
20 providing that information to CMS. So I think the
21 bottleneck is at CMS, not at NCQA.

22 MR. BUTLER: So it's a resource intensive group,

1 but I'm not sure how intense, that you've got a million
2 members, roughly, and the dual eligible SNPs, which is what,
3 2 to 3 percent of membership? I'm not sure of the
4 percentage of Medicare spending or what the per capita
5 spending is because we don't have any dollars in the
6 narrative that I found. Can you give me a sense of --

7 MS. AGUIAR: On the per capita spending?

8 MR. BUTLER: Either that or a percentage. If it's
9 2 or 3 percent of the Medicare enrollees, what percentage of
10 the totals spent?

11 MS. AGUIAR: Sorry. I'm just looking over at our
12 MA team to see if --

13 MR. BUTLER: Per capita would be fine, too. I'm
14 just getting a sense of how intense the resources are.

15 DR. HARRISON: I think they're about 1.2 to 3, so
16 20 to 30 percent more on average, I think.

17 MR. BUTLER: I thought it would be more than that.
18 Okay.

19 MR. HACKBARTH: I, too, was a little surprised at
20 that, given -- and I'm not going to be able to recite them
21 off the top of my head, but the numbers that we talked about
22 early in this effort about how disproportionately high the

1 spending was in the dual population. The differences were
2 way more than 20 or 30 percent. So does that suggest that
3 the dual SNPs are selecting the healthiest of the -- I don't
4 mean that in a pejorative way, but just happen to be
5 enrolling, for whatever reason, the healthiest?

6 DR. STUART: I think one of the questions here is,
7 because it seems to be possible for a company to have an
8 institutional SNP which one would expect would have a
9 preponderance of duals, as well as a dual SNP. So do we
10 have a sense that the institutionalized population are not
11 in these dual SNPs but are rather in institutional SNPs?

12 MS. AGUIAR: I mean, in short, we don't know the
13 direct answer to that. I think you can have a company who
14 offers both a D-SNP and then an institutional SNP, and you
15 have a dual that's in the dual SNP that then has to go into
16 the long-term care facility. I don't know at that point if
17 they stay in the dual SNP or if they would be moved over to
18 the I-SNP or not.

19 DR. STUART: That should be fairly easy to
20 determine and I think would really be helpful for us to try
21 to understand what the context is here.

22 MR. HACKBARTH: Probably what this conversation

1 does remind us of is that the dual population, on average,
2 is very expensive, but within the dual population, there is
3 significant variation in the nature of their problems and
4 their costs. Some are a lot less expensive than others.
5 The institutionalized probably would be at the higher end of
6 the scale.

7 DR. MARK MILLER: Well, and again, I wasn't
8 tracking whether you were asking specifically about the D-
9 SNPs, but when we went through this presentation, I can't
10 remember now whether it's been a year or whether it was in
11 the fall or, frankly, whether it was yesterday, because I'm
12 so hazy right at the moment, but, I mean, we went through
13 the dual eligible population and talked about the
14 expenditures and there were certain things. What Glenn just
15 said is very correct. So if you hit institutionalization,
16 it was something like a \$50,000 add-on to the per capita
17 cost. If you went into dementia, I don't remember the
18 number, it wasn't \$50,000 --

19 DR. CARTER: No, it was about 30 percent more.
20 And the institutionalized, of course, is more expensive on
21 the Medicaid side.

22 DR. MARK MILLER: Right.

1 DR. CARTER: Right.

2 DR. MARK MILLER: But just in terms of -- and I
3 assume his question was about a total cost. So they're more
4 expensive, on average, and there is a lot of variation among
5 them depending on what their conditions and where they end
6 up. I wasn't quite sure what you were asking. I mean, this
7 is a very expensive population and very expensive per
8 capita, but was that what you were even asking?

9 MR. BUTLER: Yes. I was trying to a sense of -- I
10 mean, we continually say that relatively few patients or
11 enrollees account for a large percentage of the spend, and
12 I'm looking for both the opportunity as well as the size of
13 the issue. And now I'm a little bit more confused because
14 when you pull in the institutional -- I didn't realize
15 they're not part of this dialogue here, right?

16 MS. AGUIAR: Well, it --

17 MR. HACKBARTH: They could be, but there's a
18 separate category --

19 MR. BUTLER: Yes.

20 MR. HACKBARTH: -- for institutionalized patients.
21 There's a special category of SNF for targeted
22 institutionalized.

1 MS. AGUIAR: Right, and we did receive some models
2 of care on the institutional SNPs, but we only reviewed the
3 ones on the dual SNPs.

4 DR. MARK MILLER: [Off microphone.]

5 DR. BERENSON: I was also going to contribute that
6 there's a new paper out that Gerry Anderson is a coauthor on
7 suggesting that the risk adjustor under-predicts for the
8 high end of spenders, and so the 1.23 may be low. I don't
9 know the merits of that argument, but that could be in play,
10 also.

11 DR. MARK MILLER: But just to be clear, that
12 there's three kinds of -- and you guys know this better than
13 me, but there's three kinds of SNPs, dual eligible,
14 institutional, and chronic condition. But a dual eligible
15 SNP is basically defined by the fact that the person is
16 eligible for Medicare and Medicaid. They could be
17 institutionalized. So it doesn't -- just because it says
18 institutionalized SNP, all institutionalized people don't go
19 there. You can have a lot of institutionalized running
20 through the D-SNP. It's only defined by the fact that
21 you're dual eligible. Does that help?

22 MR. BUTLER: [Off microphone.] Yes.

1 DR. NAYLOR: Thank you for this report, sobering
2 as it is. I wanted to talk about, in the body of the
3 report, and it aligns with the slide about what plans are
4 required to report. So there's this -- it seems like the
5 plans are required to report these broad categories that
6 include complex case management and quality improvement and
7 satisfaction, and I'm wondering, they don't align with the
8 measures or as well as I had thought they would be. So can
9 you comment on that?

10 MS. AGUIAR: I think we have some what we called
11 hip-pocket slides at the end. So these are the NCQA
12 structuring process measures. I think these are the ones
13 that you're referring to.

14 DR. NAYLOR: Yes. So I'm trying to figure out how
15 they -- they don't seem to align. Are they supposed to
16 align with the 15 HEDIS measures?

17 MS. AGUIAR: No.

18 DR. NAYLOR: No? Okay.

19 MS. AGUIAR: No. No.

20 DR. NAYLOR: Okay.

21 MS. AGUIAR: Right. So the HEDIS measures are --
22 some of them are subset measures. Some others were specific

1 to SNPs, and those are more clinical measures.

2 DR. NAYLOR: I see.

3 MS. AGUIAR: Do we have a -- those are more like
4 colorectal cancer screening. There is one on medication
5 reconciliation there, but that's a separate reporting
6 requirement, separate measures that are not related to the
7 structural process --

8 DR. NAYLOR: And these are dated -- are being
9 collected but not available, is that correct?

10 MS. AGUIAR: Right. Exactly.

11 DR. NAYLOR: Gosh, that's unbelievable. Okay.

12 The other thing is, is there this work on updating
13 that goes on, because there's been such movement in quality
14 measurement development and recognition of endorsed best
15 practices in care coordination and transitions. So, you
16 know, even in the last year or two. So I'm just wondering,
17 do you know if that's work in forming adaptations in the
18 structure and process measures?

19 MS. AGUIAR: When we talked to NCQA, it seemed
20 like they update the structure and process measures, or they
21 had added several elements this past year --

22 DR. NAYLOR: Okay.

1 MS. AGUIAR: -- so it seems like they go back --

2 DR. NAYLOR: Thank you.

3 DR. BAICKER: My question was along the lines of
4 the hierarchy that Glenn laid out of, you know, there's
5 something that goes on on the ground. We're not quite sure
6 what that is. There are ways that you could report that.
7 We're not quite sure how well those map. And then there's
8 how well the descriptions actually fit the report that's
9 supposed to be produced.

10 There's one more step in that chain that I don't
11 know much about that I wondered if there was any evidence
12 on. How well do those things map to the outcomes that we
13 really care about? So all these process measures are really
14 intended to look at health outcomes or overall efficiency of
15 care delivery, something that we're trying to affect through
16 the chain. I'm not even clear if we got all the way down to
17 these measures being measured well that that would actually
18 then take that next step to what we want to know about
19 deeply.

20 MS. AGUIAR: And I think that was exactly what we
21 were trying to do in sort of our second piece of the
22 analysis. Again, just we're not able to, because the HEDIS

1 measures were from 2008 and then we had structure -- we had,
2 I'm sorry, models of care for SNPs that weren't really part
3 of that. And we did find some limitations, really, with the
4 HEDIS measures themselves in the sense that they tended to
5 have small ends. There were just a lot of blanks. And
6 there's no composite measure.

7 And again, the structure and process measures are
8 not outcome measures per se, whereas the models of care --
9 and I think this is a distinction we probably didn't raise
10 before -- the models of care are really asking what is it
11 that you intend to do, and the structure and process
12 measures -- try to measure, are you actually doing it? And
13 so that would have just sort of been a nice check and a nice
14 balance if we were able to do that, but again, because
15 that's not publicly available, and the star rating measures
16 aren't publicly available, we weren't able to.

17 DR. BAICKER: So it seems clear that you can't do
18 it from the data that's available for ten different reasons.
19 I wonder if when they developed the model of care questions
20 or categories, was it based on some evidence that those
21 really mapped to the stuff that we care about, or should we
22 just cut that whole step out of the process and just beef up

1 the process measures, which are already one step removed
2 from the outcomes we care about, but at least we have a
3 better sense that they map.

4 DR. CARTER: I got the sense when we talked with
5 NCQA that their structure and process measures were evidence
6 based, and they did a careful job of doing sort of panels of
7 experts and going to the literature. So I'm pretty
8 comfortable with those.

9 We've been thinking about sort of what kinds of
10 outcome measures would you want about these plans, things
11 like, you know, cost and maybe patient satisfaction and sort
12 of -- if you wanted to compare these to MA plans, look at
13 hospitalization rates and ER use and rehospitalizations and
14 things like that. And right now, those aren't required as
15 reporting measures. But we agree with you. And so you'll
16 see in the last section of the paper, we sort of open up,
17 aren't there other quality measures you would want to have
18 about these plans, and I think the answer is yes.

19 MR. GEORGE MILLER: Yes, two quick questions.

20 One, can you describe to me how they determine or the
21 definition for the target populations? How does that
22 process work, because I was concerned about the statement

1 saying that you may choose or select not to choose some
2 folks to go into the target population.

3 MS. AGUIAR: I believe the question -- let me see
4 if we have it -- is quite simple, just a description of the
5 SNP-specific target population. So that's the question
6 that's on the model of care element, and again, what we saw
7 was most of the SNP, the models of care saying that they
8 were enrolling all duals or full duals.

9 MR. GEORGE MILLER: Okay.

10 MS. AGUIAR: And, you know, so if they are
11 enrolling a dual subset, that information just wasn't
12 available. I think it's more the question on the model of
13 care element and then the way that those questions were
14 answered than necessarily -- we actually really weren't even
15 able to assess what the actual target populations really
16 were and sort of how they are selecting those, just given
17 the information that's available.

18 MR. GEORGE MILLER: Okay. And to follow up on
19 Jennie's question, particularly about the cultural
20 assessment, is there a determination of cultural
21 competencies for both the care managers and those providing
22 care, particularly for those populations that communication

1 may be an issue, and is that part of the process, to
2 determine cultural competencies? Is that going to be in the
3 lexicon as we describe the model of care, as well, to
4 determine cultural competencies?

5 DR. CARTER: You know, that's a good question and
6 I'd have to get back to you. There are a couple of places
7 that we can look. Some of the models of care descriptions
8 require them to discuss how they train their personnel.

9 MR. GEORGE MILLER: Right.

10 DR. CARTER: And then in the attestation, there
11 may be some questions about, you know, what kind of
12 translation services do you have available and stuff like
13 that. So we can get back to you on that.

14 MR. GEORGE MILLER: Thank you.

15 MR. HACKBARTH: [Off microphone.] Round two
16 questions or comments? Tom?

17 DR. DEAN: Just a brief comment. Kate's question
18 provoked an issue which doesn't really relate to this
19 specific discussion, but it does. I mean, I think her point
20 is terribly important because we really need to tie the
21 measurement to outcomes. Now, sometimes you can do that and
22 sometimes you can't, but I participate, and I don't have

1 much experience with this program, but just last week, I was
2 in a quality assurance meeting for a nursing home and they
3 had just got dinged by their inspectors and the dietary
4 manager was having a fit because they had been written up
5 because they weren't using a hand soap that was approved for
6 dietary use, even though they are absolutely prohibited from
7 ever touching the food. And so, I mean, it's things like
8 that that get implemented when they really have no potential
9 for any benefit to the beneficiaries or the patients or
10 whatever.

11 So I think we need to continually push to make
12 sure there is some sort of tie of the requirements to some
13 outcomes that really mean something. Actually, that's a
14 very general comment, but I think it's so easy for
15 inspectors in various ways to measure things that are easy
16 to measure and latch on to those rather than to do the
17 really hard job of saying, does this really make a
18 difference in the long term.

19 MR. ARMSTRONG: To the specific questions, can the
20 models of care be used to evaluate these SNPs and the second
21 question around assessing the plans, the integration of the
22 Medicare and Medicaid plans, you know, it's hard for me to

1 answer that question. And I, too, I come back to, so, to
2 what degree is the information coming forward through this
3 reporting actually telling us -- I mean, dual eligibles is a
4 population that we should care deeply about or a lot of
5 obvious reasons. SNPs are an approach to organizing,
6 managing, integrating coverage and care in a way that we
7 would hope would achieve distinctively better outcomes, and
8 if not, we would ask, well, why are we doing this? But if
9 we can't measure that, then we can't determine that.

10 And so I would just say I think we should continue
11 to push these questions forward. Whether this model of care
12 approach is the right answer, it's hard for me to know, but
13 I think this is an important topic we should continue to try
14 to push ahead on.

15 MR. HACKBARTH: So let me pick up on Scott's
16 comment. I'm trying to link this conversation to the
17 broader discussion we've been having about dual eligibles.
18 As Scott says, this is a very important population. It's a
19 very vulnerable population. It's an expensive population.
20 It's a complicated population to care for. So part of our
21 journey has been -- and we started noting how if people were
22 in fee-for-service Medicare and Medicaid, there are all

1 sorts of barriers that crop up to these patients, these
2 complicated patients getting the care they need and various
3 efforts to shift the cost back and forth between the
4 Medicare and Medicaid programs. So that's not a productive,
5 constructive approach.

6 So we started looking at models that try to take
7 on the task of overcoming those barriers here in separate
8 insurance programs and integrate the care better, and this
9 is one of the models, but not the only one. There are PACE
10 programs and others.

11 But one of the questions that's been in the
12 background, at least, actually raised explicitly, is, oh, if
13 there are good models and enrollment is low in those models,
14 should we be doing something to at least nudge dual
15 eligibles into better systems? So that's sort of the
16 framework I've got in my head for the conversation that
17 we're having.

18 So now I look at this and it seems to me that
19 based on the information we've heard today, it would be very
20 hard to make the case that, oh, dual eligible SNPs are a
21 place that people ought to be nudged into.

22 MS. BEHROOZI: Yes, and certainly just taking as a

1 baseline, as a starting point, the concern for the
2 beneficiaries and the lost opportunities to do good things
3 for the beneficiaries is the flip side concern, that there's
4 all this money going, you know, program money going to
5 agencies that have exemptions from the rules about marketing
6 and window periods and things like that. You know, this is
7 not a statement against all dual needs, dual eligibles,
8 rather, SNPs, because I'm very familiar with a not-for-
9 profit dual SNP in New York that cares very deeply about
10 care coordination and taking care of their beneficiaries.
11 But we're making it pretty easy for people to bring in
12 people at 1.2 level risk adjustors all year and we don't
13 allow that for other kinds of MA plans.

14 I was just very unhappy when I read that plans
15 described, when they did submit MOCs that you could actually
16 get some information from, they described limiting their
17 care coordination programs to specific enrollees, and I
18 wrote in the margin, why can they do this? I mean, really,
19 what is the point of allowing this special designation for
20 these plans and giving them all this extra money?

21 DR. STUART: I think this is a really important
22 chapter and I think what you hear around here is interest in

1 making sure that we are, first of all, posing the right
2 questions, and then, secondly, getting the answers to those
3 questions, and so I'd like to step back a bit and put a
4 point that Peter did, or Peter asked, about what's the core
5 eligibility population here and how does that compare to
6 others that are not enrolled.

7 And this, I think you should be able to do, is
8 first of all start with the number of dual eligibles, say,
9 in 2008. What's the split in terms of those that are in
10 fee-for-service as opposed to MA? And then within the MA
11 subset, what's the split in those that are in SNPs and non-
12 SNPs? And then on the SNP side, what's the split on the
13 dual chronic and institutional, because they could be in the
14 chronic side, too. There's nothing that says that they
15 couldn't be there. So at least we have some sense of who's
16 targeting whom.

17 And then it would be useful, if you can do this,
18 would be to look at the characteristics of people who are in
19 these different bucks and to see whether they really differ.
20 We're not going to know exactly who is going to be helped
21 until we have some idea about what their characteristics
22 are, and we don't know whether the targeting is right, so at

1 least something. And I don't have a whole list of
2 characteristics, but obviously total spending would be one
3 of those that I would think you would want to look at.

4 And then last, and this may be even more
5 difficult, would be to see whether there's any dynamic here.
6 It looks like the most recent data that you have is 2008. I
7 know these things are new, but I don't really have a sense
8 of whether there is a dynamic. In other words, did the
9 company just come in and then they're there, or is there an
10 ebb and flow? Is this something -- an idea that the
11 companies got into, thought that they could make some bucks,
12 and now are moving out? Some sense of that. Thanks.

13 MS. HANSEN: I'd like to build on the request for
14 perhaps describing the population again, I think starting
15 with Peter and then Bruce's comment about understanding what
16 the dual population is, because there are different groups
17 of them. So if we could subset them, that some of them
18 might be a multiplier of 1.2, but others might be actually a
19 much larger multiplier because I think that's probably a
20 bias of just the group that I'm much more familiar with.
21 But being able to say the duals are not a universal group
22 and to be able to do the subset even of the duals. From

1 previous work that we've done, I know we have that. So just
2 putting probably the proportionality, Peter, of how large
3 and what group is most affected by this.

4 I'd like to bring back up the whole Medicaid
5 contracting and how much of an issue that was that we
6 discussed previous, and it sounds like there's more work
7 that again has evolved in that, and that CMS has a technical
8 advice center now to help some of the States move this
9 along. I just would like to kind of stay on top of what are
10 the criteria that should be in place for any State that has
11 this, especially if you have four large companies that have
12 multi-sites, what should be in each? What's the best
13 practice of the Medicaid contract to Medicare in each of
14 these States?

15 Another point here that I see that I'm kind of --
16 probably a little surprised about, especially given the
17 context of some of the areas of nebulousness that exist,
18 that already there is a whole -- in the text we have that
19 CMS is developing the scoring methodology for NCQA to use
20 for rating these plans and that if they come out with a good
21 score, maybe they don't have to get rated for five years.
22 And so already we're into a kind of, almost the

1 accreditation process, so far ahead when there's so much
2 kind of gray zone that's going on here.

3 So that's one of the questions -- not questions,
4 it's a comment I have, that we moved ahead to begin to kind
5 of give some passes on a model that still isn't well defined
6 yet. So that's probably just a notation that I would have,
7 that it's great that they want to do this, and I firmly
8 believe that oftentimes you get over-viewed, over-regulated
9 on the flip side, but when we don't know what we are
10 expecting as outcomes, how do you pass that kind of judgment
11 already to give accreditation cycles already.

12 And then I want to affirm what I think Mary was
13 bringing up, is just the ability to get the rating systems
14 and the data out there, and I do believe that if these are
15 SNP MA plans within the larger MA, they shouldn't be just
16 blending the two programs together to come out with one
17 score. So somehow, even though they are small "n"s, and
18 that is the nature of oftentimes this population. It will
19 be a smaller "n," that they have their own star rating
20 system at one point, even though they're owned by a
21 centralized entity.

22 DR. BERENSON: To pick up some of the similar

1 comments, it does seem to me that the SNP program is
2 differentiated from just Medicare Advantage generally
3 because they think they have a model of care for a
4 particular population. It just seems to me CMS needs to
5 ultimately have that as a core of their program monitoring,
6 that the program does have a care model and detail and that
7 they are meeting what they say they are doing. I think in
8 this area, structural criteria are real important and I
9 would hope that NCQA's criteria are flexible enough to
10 permit variation that will be inevitable with different SNPs
11 doing a core set of activities, but in somewhat different
12 ways. And I would include in that the Medicaid coordination
13 as just an essential part of that. So that, to me, is sort
14 of the core part of monitoring, and it sounds like they're
15 going in the right direction after sort of not starting
16 quite right.

17 I, in general, like outcome measures more than
18 process measures. This is a tricky area because some of the
19 clinical outcome measures may not be particularly
20 appropriate. I'm not sure what to do with mortality rates,
21 for example, in this population.

22 One area, though, I do think we can probably agree

1 is real important would be preventable rehospitalizations,
2 which I think we would focus on across the entire program.
3 That seems appropriate here.

4 On cost, this is a capitated program, so to some
5 extent, almost by definition, we've got cost measures.
6 Either the plan will live within its capitation or it will
7 leave because it can't make it. I don't know that we -- as
8 sort of monitoring the program, need to see if this is a
9 good investment of public funds, but as a way of measuring
10 performance of an individual plan, I'm not sure that helps
11 us very much. So I would go very heavily towards patient
12 and caregiver experience measures in this area, and
13 recognizing, I think, there are subpopulations amongst the
14 duals that might have some unique -- I mean, the disabled
15 population is different from sort of the frail elderly
16 population. I think we'd want to just be -- this is a great
17 area to work on in those experience measures and I think
18 that would be a core of the monitoring. We have a capitated
19 payment system. The potential -- with care models that
20 presumably would give higher levels of care but the same old
21 threat of stinting somewhere. So if we ask the patients and
22 the caregivers whether the experience is a good one, I think

1 that would be a package.

2 DR. CASTELLANOS: Just a simple question. Has
3 there been any coordination with the MACPAC group, or
4 coordination in working together to discuss whether they're
5 addressing this issue?

6 MS. AGUIAR: We do, both at the staff level and
7 then at Mark's level, have frequent interactions with
8 MACPAC. I believe that they themselves are in the process
9 of defining what their work agenda is going to be, and so I
10 think where there are areas of overlap, of course, we're
11 definitely open to collaborating with them. But I think --
12 I believe, and I'm not sure if this is finalized, that they
13 were also interested in looking at the sort of pre-dual
14 population on the Medicaid side, in which case would not
15 overlap with the population that we really look at. But I
16 think, again, we do coordinate with them fairly frequently
17 at both our level and at Mark's level.

18 MR. HACKBARTH: And I guess about a month ago,
19 Bob, Mark, and I met with Diane Rowland, the Chair of
20 MACPAC, and David Sundwall, the Vice Chair, and Lu
21 Zawistowich, the Executive Director, and talked about our
22 agendas and talked about this particular issue a bit, as

1 well. And then I think it's next month, I am going to meet
2 with all of the MACPAC Commissioners and talk about our
3 common agendas. So that work is underway.

4 MR. BUTLER: So one of the few things I remember
5 from graduate school is Donabedian teaching me structure
6 process outcome, and I think Bob kind of hit on some of
7 this. The structure process things are part of these models
8 that we ought to get a lot clearer, so I agree completely
9 with that, and the outcomes are going to be a little harder
10 to kind of measure.

11 Now, having said that, this strikes me, as good as
12 the paper exercise might get, it's kind of like until the
13 Joint Commission came in and did tracers and pulled out
14 random charts and said, let me see that you're following --
15 I mean, that's very effective in testing whether the model
16 is being used or not, and this kind of strikes me as,
17 without, again, over-accrediting and over-regulating, we may
18 perfect the paper exercise here, and until you have somebody
19 come in and randomly pick out Joe Jones and say, I wonder if
20 they're adhering to this model, you probably -- I mean, that
21 would be a better test to see if these things are working,
22 probably, than chasing outcome measures that are going to be

1 difficult to -- I'm not saying you shouldn't have those, but
2 I think you're going to have to kind of look under the
3 covers and see how these things are working to test their
4 effectiveness a little bit better.

5 DR. NAYLOR: I'm trying to think about all we have
6 accessible to us that should accelerate us on a path here,
7 and the continuity of care record is somewhere out there
8 that is a really good review of things that are important to
9 the dual eligible population. The PACE program has already
10 spent a lot of time thinking about outcomes and processes
11 that are important for this population.

12 And I really do agree -- I mean, I think that we
13 really need to move. I mean, there are components of the
14 analytical framework that you have that are core, key, and
15 there are pieces like access or communication or continuity
16 that also you might want to think about as dimensions. But
17 until we get to kind of pairing some of these processes with
18 what people care about or their experience, their quality of
19 life or function or whether or not they're using a lot of
20 health resource utilization unnecessarily, those kinds of
21 things, I just don't think we're going to get to real
22 improvement until we pair them.

1 And so I think we should think about encouraging
2 the use of endorsed measures that are getting us a little
3 bit closer toward these areas. There's a lot of work going
4 on on actually how to measure care coordination itself, not
5 just its domains. And then, you know, really promoting use
6 or development of robust measures of things that this
7 population really cares about, and they care about quality
8 of life and they care about function. And many of them are
9 cognitively impaired and they can only tell you so much, but
10 we ought to be measuring the things that are important to
11 them or to their family caregivers.

12 And I think that should be the rules across all
13 our dual eligible populations and not -- so then you get to
14 say, well, how does this model SNP fare relative to all the
15 other dual eligible programs? I mean, that's the comparison
16 group that we should be looking toward.

17 So anyway, I like the way this is going and I like
18 your kind of getting to the analytical framework. I just
19 push it, like everybody else, further to get to real
20 expectations and accountability that things are going to
21 change in these people's lives.

22 DR. BAICKER: Yes, just to marry those comments,

1 Peter's point is extremely well taken that it's all well and
2 good on paper, but what's going on in reality and that we
3 need to feel confident that those measures matter. But then
4 I do think it's really important to get both the quality of
5 life and satisfaction outcomes and the measurable health
6 outcomes, like readmissions or infections or whatever
7 outcome we think is likely to be improved by this because
8 I'm sure there's a lot left to be learned about what good
9 coordinated care is.

10 So we want measures that are real, based on what's
11 going on on the ground, but we also want to be measuring the
12 right thing and marrying the more rich outcomes with the
13 process measures would help us know, you know what? These
14 guys are doing a great job at doing process X that they said
15 they were going to do. It just turns out process X doesn't
16 matter or isn't effective, and here's an opportunity to
17 advance the science in how to better provide that care.

18 DR. BORMAN: To try and deal with some of the
19 practical questions that you've asked about the chapter, I
20 would say that what struck me here is, to some degree, in
21 addition to the big issues that have been talked about, is
22 the disconnect between the model piece and the survey, and

1 basically it's sort of like having a very structured,
2 objective question versus a rather subjective kind of essay
3 question, right, a little bit. Both bring valuable
4 information. At a relatively nascent stage, the more that
5 you can capture, particularly these process and structure
6 questions, are probably relatively well captured on this,
7 you know, check the box yes or no, do you do this. It's
8 essentially a true-false question, right, format and it's
9 pretty clean, and as much in process sometimes and structure
10 lend themselves to those kind of answers.

11 To the extent that we can convert things that are
12 now sort of supposed to be covered in the essay and maybe
13 aren't getting covered, maybe those do need to get
14 converted, as you suggest, or at least you hint at, I think,
15 in the chapter, that they do belong more in this survey
16 approach.

17 That then allows the essay part, if you will, to
18 be somewhat more focused on kind of what sets this SNP apart
19 or some of these fuzzier kinds of things about what is the
20 added value, and I think what you've pointed out to us is
21 that the guidelines for the content of that should be
22 crisper. That, to me, sounds like a little more of a

1 research project or a thought project than just moving some
2 of the questions over to the survey.

3 So I would say that in terms of a recommendation,
4 if we could move some stuff to the survey and then help to
5 set some guidelines for moving the essay part forward, if
6 you will, taking into account all these other big picture
7 things we're going to find out in the meantime, that that
8 would be the biggest service to this population.

9 MR. HACKBARTH: Okay. Thank you very much. I
10 look forward to hearing more soon.

11 Our next session is in supporting quality
12 improvement. Whenever you're ready, Anne.

13 MS. MUTTI: Okay. This presentation continues our
14 work on ways that Medicare can encourage quality improvement
15 and offers some draft recommendations for your
16 consideration. By virtually all accounts, the pace of
17 quality improvement has been slow. There has been some
18 improvement, but there has not been the kind that many
19 envisioned in the wake of the IOM Report 10 years ago. That
20 is the "To Err is Human" report. The Commission has
21 recommended payment changes to encourage improvement -- and
22 here I'm thinking of things like pay for performance,

1 medical homes, preventable readmissions, a payment policy to
2 deal with those -- but it may be that to accelerate
3 improvement we need to pair those payment changes with a
4 revitalized technical assistance program, updated regulatory
5 incentives, and a public recognition program.

6 It may not seem like it to you with all that you
7 have on your plate, but we've actually been talking about
8 this issue for nearly a year and a half. In October of
9 2009, we held an internal panel discussion with stakeholders
10 and experts, and actually Mary Naylor was a member of that
11 panel before she was a Commissioner. As a Commission, we
12 started talking about this publicly in November of 2009,
13 talking about different opportunities for improving the
14 programs. In the spring of 2010, we had leaders from Denver
15 Health and Parkland Hospital come in and talk about how they
16 have improved quality. And we included a chapter in the
17 June 2010 report to Congress on these issues, just talking
18 about options.

19 More recently, in November we had Chris Queram and
20 Dr. Bob Wachter, two national experts on quality, present
21 before the Commission, and we got the opportunity to hear
22 their reactions to some of the thoughts we were discussing.

1 The policy options we'll discuss today reflect a
2 multi-pronged approach to quality improvement. The approach
3 would first focus technical assistance on low performers,
4 and this is a strategy to complement our payment policies,
5 address health care disparities, and minimize displacement
6 of private sector resources.

7 To improve the chance that this assistance will
8 bring about genuine improvement, it seeks to improve
9 engagement among providers by giving them the choice of who
10 assists them and the flexibility in how they use their
11 resources.

12 It also increases the number and variety of
13 technical assistance entities who can assist providers,
14 improving competition and ideally the quality of the
15 technical assistance. But with that flexibility should also
16 come greater accountability, so this package of
17 recommendations also includes one that increases
18 accountability by creating intermediate sanctions for
19 persistent low performers.

20 And, finally, to provide additional motivation for
21 the full range of the spectrum of providers, it would
22 improve public recognition of high-performing providers.

1 These draft recommendations would mean fundamental
2 change to the QIO program, which funded at \$1.1 billion over
3 three years, supports currently 41 private organizations
4 offering technical assistance to providers in all states.
5 Some of these changes I've just outlined parallel a 2006 IOM
6 report, the recommendations that came out of that report, as
7 well as some recent policy proposals that were in the
8 President's budget. But this package of recommendations
9 would go further, particularly in directing resources to low
10 performers and how it weaves together assistance in a
11 revamped QIO program and accountability through the
12 conditions of participation.

13 In the Ninth Scope of Work, which is the three-
14 year contract for QIOs that ends this summer, CMS targeted
15 some of the QIO resources to low-performing providers, but
16 it's not clear that they are going to maintain this
17 direction. We don't yet know the details of the 10th Scope
18 of Work. It's due out any moment now.

19 Targeting technical assistance to low-performing
20 providers, however, has several advantages and could be an
21 appropriate way to focus the majority of Medicare's quality
22 improvement efforts.

1 First, targeting to low performers can help
2 providers respond to new payment policies that hold them
3 accountable for outcomes like hospital-acquired infections
4 and readmissions. By directing resources to low-performing
5 providers, we should at least partly allay concerns about
6 holding providers accountable when they may face a
7 challenging patient population. The idea here is that the
8 goal of high performance should exist for all patients,
9 regardless of socioeconomic status or race, but those
10 expectations may be more likely to be met if they are
11 combined with a policy that recognizes that time-limited
12 resources may be needed to elevate the provider's ability to
13 address particularly challenging environments. So instead
14 of lowering standards, we're targeting assistance to those
15 who need it most.

16 Second, by focusing on low performers, we would
17 hope to significantly address disparities in care. Where
18 you get your care matters, and this matters especially for
19 minorities because they tend to receive most of their care
20 from a limited number of physicians and hospitals, and those
21 providers tend to have lower quality.

22 For example, one study found that among African

1 American beneficiaries in a market with high racial
2 segregation, the risk of admission to a high-mortality
3 hospital was 35 percent higher than for whites in the same
4 market.

5 Another study, which uses volume or experience as
6 a proxy for quality of care by looking at services where a
7 volume-outcomes relationship has been established, found
8 that African Americans in New York City tended to physically
9 pass a higher-performing hospital and get their care at
10 lower-performing hospitals.

11 A study on minorities and readmissions came out
12 just last week, also showing that hospitals that tend to
13 serve a high portion of minorities have higher readmission
14 rates, and this echoes something that we also looked at a
15 couple years ago or a year ago.

16 Third, this type of focus should minimize the
17 likelihood that public resources would displace equally
18 effective private sector resources. High-performing
19 providers likely already have the resources necessary to
20 make investments leading to high-quality care. Providing
21 additional assistance to them effectively subsidizes their
22 success using scarce public resources.

1 A key issue of course is how we measure low
2 performance. In the paper we were envisioning a broad
3 measure that includes a variety of outcomes, process, and
4 patient experience measures. But I could see that might be
5 something we want to talk further about. We also have
6 concerns about communities rather than just isolated
7 providers that are achieving poor outcomes and think that
8 coordinated efforts directed at the community may be
9 particularly appropriate in certain cases. And I'll come
10 back to this thought in a moment.

11 But first I want to acknowledge a number of
12 concerns some might have with focusing on low performers.
13 One concern is that some providers are unlikely to improve
14 even with assistance and that our effort will be for
15 nothing. When certain ingredients are absent -- effective
16 leadership, for example -- culture change and quality
17 improvement may be elusive, even with best technical
18 assistance. This possibility may be minimized by empowering
19 those providers with choice and flexibility in which a
20 technical assistance agent helps them. However, if despite
21 these changes a provider is resistant to improving quality,
22 this package proposes that intermediate sanctions be

1 available to further induce change.

2 Another concern with focusing on low performers
3 may be a sense that QIO resources could be useful in
4 developing new strategies to improve quality and communicate
5 those improvements. And while this need is genuine, we note
6 that other federal agencies and programs as well as private
7 sector resources may be better oriented to this mission.
8 AHRQ has demonstrated experience and success in this area --
9 funding efforts to reduce central line infections and
10 improving the discharge process -- and it is possible that
11 the CMS innovation center may also have a role in this area.

12 It could also be argued that a focus on mid-level
13 performers would be more successful; their problems may be
14 easier to solve and improvement more evident. The concern
15 here, though, is that by directing public resources to the
16 mid-level providers who may stand poised to improve, fewer
17 resources are available to improve the care of those
18 beneficiaries, who are disproportionately minority, who
19 received care from the lowest performers.

20 That said, some flexibility may be warranted. A
21 reasonable policy option may be to direct the clear majority
22 of technical assistance resources to low performers, but

1 allow the remainder of resources to be available for
2 community-level assistance to communities struggling with
3 poor outcomes. These communities would have poor performers
4 but may also have higher-performing providers. Community-
5 level quality improvement likely involves reaching out to
6 all of them. In addition, the Secretary may choose to use
7 some the resources for broader community outreach
8 activities.

9 So a recommendation, a draft recommendation could
10 read: The Secretary should target a substantial majority of
11 technical assistance funding for quality improvement to low-
12 performing providers, and the remainder should be targeted
13 to community-level quality improvement.

14 Here we're saying that spending implications are
15 budget neutral because really what we're doing is just
16 reorganizing and reallocating current QIO money. And for
17 the beneficiary and provider, we're expecting improved
18 quality of care for patients of low-performing providers,
19 and we recognize that we're redistributing or potentially
20 redistributing quality improvement funds among providers.

21 As I noted earlier, other changes could be made to
22 the structure of the program that may increase the chance

1 that technical assistance is successful. Currently
2 technical assistance funds go directly to the designated
3 QIOs, and it is incumbent on them to reach out to providers
4 and encourage improvement. However, if the funds went
5 instead to the poor performers directly, who in turn could
6 use the grant money to purchase technical assistance from a
7 qualified technical assistance agent of their choice, we
8 might be more likely to see the engagement and culture
9 change that needs to occur for quality improvement to take
10 root.

11 Empowerment comes from both flexibility of how to
12 use the funds and the ability to choose the technical
13 assistance agent. Accordingly, technical assistance agents
14 working with their clients should have that flexibility to
15 determine the manner in which the assistance is used. And
16 we would expect the focus to vary by provider and community.
17 For some, quality problems may stem from meeting the needs
18 of a poor population or from a geographically isolated
19 population. For others, it may be that they don't have an
20 understanding of how to collect their data and even identify
21 what problems they have. And for others, it may be just
22 staff retention. They've trained their people, but they've

1 all left so quickly that the training was for nothing. So
2 this technical assistance could be more tailored to the
3 needs of the provider and the community that it serves.

4 To enable the market for technical assistance
5 agents to form and work well for low performers, CMS would
6 need to provide some structure. For example, it could
7 create an online marketplace, where providers can see their
8 choices of qualified assistance agents. And being able to
9 access this information in one place might facilitate the
10 best match between providers and assistance agents.

11 So a draft recommendation for your consideration
12 is, therefore: The Congress should allow the Secretary to
13 provide funding for time-limited technical assistance to
14 providers. The Congress should require the Secretary to
15 develop an accountability structure to ensure these funds
16 are used appropriately. Again, the spending implication is
17 budget neutral, and the expectation here is for improved
18 quality of care for patients, and providers would having
19 greater control over their quality improvement funds.

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

1 providers themselves, like Geisinger, and consulting firms.
2 Ideally, our lowest performers should have the option to
3 access the expertise of these organizations. Under the
4 current QIO program, however, they do not. A variety of
5 requirements serve as barriers to entry for other
6 organizations. Indeed, in the last Statement of Work, CMS
7 awarded a new QIO contract to only one new contractor, and
8 that was another QIO.

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

16 A third barrier is the requirement that QIOs also
17 perform regulatory oversight as well as field and
18 investigate beneficiary complaints. This dual role creates
19 some problems. First, to our point here on competition, it
20 restricts the type of organization that will compete to be a
21 QIO. Second, which is not directly on point but still very
22 important, it creates a conflict of interest that can hamper

1 the effectiveness of technical assistance agents. It's hard
2 to be a trusted consultant to the provider when you also may
3 be called upon to investigate them. And it's hard to
4 advocate for the patient when you are trying to earn the
5 trust of the provider. And, also, we may be creating a
6 fragmented system for capturing beneficiary complaints --
7 and really all patient complaints -- by having so many
8 different organizations handle the complaints, and this can
9 mean that we're missing patterns of problems that could help
10 target our resources on our surveys more effectively.
11 Currently complaints are fielded by 41 QIOs, state health
12 agencies, state medical boards, accrediting agencies, and
13 maybe there's even more. Creating a single entry point for
14 complaints may be a far more effective way to use this
15 information.

16 Our recommendation here, though, speaks to the
17 competition angle here and removing barriers. So the Draft
18 Recommendation 3 here reads: The Congress should authorize
19 the Secretary to define technical assistance agents so that
20 a variety can compete to assist providers and to provide
21 community-level quality improvement. The Congress should
22 remove requirements that the agents be physician-sponsored,

1 serve a specific state, and have regulatory
2 responsibilities.

3 Again, we envision this to be a budget-neutral
4 recommendation and also that it would result in improved
5 quality of care for patients. This recommendation very much
6 echoes several of the IOM recommendations made in 2006, and
7 also in the FY2012 President's budget are similar proposals,
8 although they are scored as small or as savers. And to be
9 clear, this means that the regulatory responsibilities,
10 including beneficiary complaints, would not just disappear.
11 They would be designated for another agency to perform.

12 Now I'll pivot off of QIOs to talk about
13 conditions of participation, COPs, and these are the
14 minimum, largely structural standards that certain
15 providers, although not physicians, must meet to participate
16 in Medicare, and they are a lever, just like technical
17 assistance that Medicare can potentially better use to drive
18 change. Surveyors and accreditors are in our nation's
19 facilities on a regular basis enforcing the COPs, and what
20 they are enforcing and how they do this can matter.

21 We don't have a specific recommendation on this
22 today, but we want to include a discussion of possibilities

1 so that we're leaning forward on the need for change.

2 For example,, while the COPs require that
3 facilities conduct "quality improvement activities," they do
4 not require that hospitals, for example, adopt particular
5 processes that are known to improve quality. They also do
6 not require hospitals to demonstrate improvement or efforts
7 to improve their performance on publicly reported quality
8 measures. Yet anecdotal evidence suggests that better-
9 performing facilities are adopting process improvements,
10 whether it's checklists to prevent central line infections,
11 medication reconciliation, adhering to hand-washing
12 protocols, and these facilities are focused on measuring and
13 improving their performance on widely accepted quality
14 measures.

15 So the COPs could be updated to build in and
16 reinforce the importance of making the process changes that
17 improve outcomes. At the same time, the COPs could be
18 changed to reduce the perception that being surveyed for
19 compliance with the COPs is like "death by a thousand duck
20 bites," as Bob Wachter put it when he was here last. And
21 this kind of picks up on a point I think, Tom, you were just
22 making, too, about the hand washing.

1 Some possible new requirements that could be
2 included in the COPs are compliance with hand-washing
3 protocols and transmission of discharge instructions in a
4 timely way. And Dr Bob Wachter suggested these two
5 requirements to you in November, noting the advantage that
6 they really reflect the whole facility's commitment to
7 quality improvement and aren't just isolated in a single
8 department.

9 Another option is requiring compliance with the
10 Joint Commission's national patient safety goals. These
11 include things like checklists to avoid central line,
12 evidence-based practice for preventing surgical site
13 infections, and time-outs before procedures.

14 The COPs could also require hospitals to
15 demonstrate physician involvement in patient safety
16 activities. Peter Pronovost has written about this
17 repeatedly, suggesting that hospitals provide greater
18 support for physicians to participate.

19 Or perhaps facilities could be held accountable
20 for improving their performance on widely accepted measures.
21 The Joint Commission is exploring how it could build in
22 consequences for failure to do so into its accreditation

1 process.

2 Again, we don't make a specific recommendation
3 here; instead we're just proposing to talk about it in the
4 text.

5 Now, we'll consider enforcement of the COPs, and
6 here we do have a draft recommendation. One problem with
7 enforcement under the current survey and accreditation
8 process, especially for hospitals, is that the consequence
9 for failing is so extreme -- exclusion from the Medicare
10 program -- that such action is rarely taken. For this
11 reason, the intermediate consequences or sanctions that had
12 a real possibility of being imposed could induce providers
13 to improve care and make the accreditation and survey
14 process more effective. In 1990, an IOM study recommended
15 that intermediate sanctions be adopted, as did MedPAC in
16 1990.

17 There are a range of types of intermediate
18 measures. For example, under one approach, low-performing
19 providers could be identified publicly. Already under
20 Medicare's Special Focus Facility program, nursing homes
21 designated as deficient are identified publicly. Similarly,
22 Hospital Compare identifies poor performance on specific

1 measures.

2 Under another approach, if insufficient
3 improvement was found after some period of time, the COPs
4 could require that the board submit a corrective action
5 plan. The plan would need to be approved by CMS to avert
6 exclusion from the program, and the corrective action plans
7 could describe the types of activities the hospital, or
8 other provider, would pursue as well as any management
9 changes that were necessary. There is precedent for this
10 approach with nursing homes. If a nursing home is cited
11 with one or more deficiencies that constitute immediate
12 jeopardy to resident health or safety, the law allows for
13 "federal temporary management." This allows for CMS to make
14 staffing and management changes on a temporary basis.

15 More aggressive steps could also be contemplated.
16 For example, CMS could prohibit hospitals from performing
17 elective procedures in a given service line for some period.

18 So that brings us to Draft Recommendation 4, which
19 reads: The Congress should require the Secretary to develop
20 and impose intermediate sanctions for persistently low
21 providers. Spending implications, again, are budget
22 neutral, and here we're expecting it should improve quality

1 and recognize that some providers would be adversely
2 affected. And what we're also wanting to make the point
3 here, too, is that we're envisioning you might give
4 technical assistance. If the provider still does not
5 improve, intermediate sanctions could be appropriate.

6 Finally, providers meeting a relatively high
7 standard of care could be publicly recognized by Medicare.
8 PPACA requires that the Secretary publish hospital scores on
9 value-based purchasing -- the VBP program -- on Hospital
10 Compare, and this actually goes part of the way of what
11 we're talking about to making information available to
12 consumers. This disclosure could be the basis for
13 recognition, but thought may be given to two particular
14 aspects of the program design. One is whether simply
15 posting a score, a raw score on Hospital Compare is a
16 sufficient way to communicate with beneficiaries; it may be
17 difficult for them still to interpret. A designation as a
18 blue ribbon provider, as a platinum provider, may be more
19 digestible for consumers and then more effective in helping
20 guide their care choices.

21 A second consideration is whether the definition
22 of high performance is best met by the measures included in

1 the VBP program. They are limited somewhat. They focus on
2 AMI, pneumonia, and CHF initially, although over time they
3 will pick up patient safety measures and mortality. But
4 they don't include things like readmissions or some of the
5 quality efforts I discussed like hand washing, discharge
6 instructions, checklists that could be part of the
7 conditions of participation and ascertained in the survey
8 process. So including these other factors in the
9 designation may provide a more comprehensive view of
10 quality.

11 So the draft recommendation on this point could
12 read: The Secretary should establish criteria for high
13 performance to publicly recognize those providers
14 demonstrating superior quality. Again, spending implication
15 is budget neutral, and by definition we're expecting
16 improved quality from providers and for beneficiaries.

17 So that completes the range of options we wanted
18 to give to you for your discussion today. I'll leave this
19 summary slide up here to help prompt you, but I'm happy,
20 obviously, to flip back to other slides. Thanks.

21 MR. HACKBARTH: Thanks, Anne. Good job.

22 So these are draft recommendations. We want to

1 get your reaction to them today, and provided it's generally
2 positive, we would have votes on final recommendations at
3 the April meeting for inclusion in the June report.

4 Let me kick off the clarifying questions. I have
5 two things that I need you to help me understand. One has
6 to do with the conditions of participation on the one hand
7 and the deeming process on the other. My crude
8 understanding of this is that a provider has two tracks to
9 choose from. They can submit to the survey and
10 certification process, which is based on the conditions of
11 participation. Or, alternatively, they can choose to be
12 accredited, in the case of hospitals by the Joint
13 Commission, against the accreditation standards established
14 by the Joint Commission.

15 My crude understanding is that the Joint
16 Commission's standards are not the same as the conditions of
17 participation, cover the same areas but they may be
18 different or higher, but they're not exactly the same.

19 So one question is: How many providers opt for
20 the survey and cert. based strictly on conditions of
21 participation versus the deeming process? So, in other
22 words, how many people would be affected, what proportion of

1 providers would be affected by changing the conditions of
2 participation per se.

3 A related question is: If we were to adopt
4 intermediate sanctions through the survey and cert.
5 conditions of participation track, does that mean that the
6 Joint Commission needs to do something analogous on the
7 deeming track?

8 Is that set of questions clear?

9 MS. MUTTI: Okay, so going back to the first one,
10 yes, and it depends on what type of provider you are.

11 MR. HACKBARTH: Sure.

12 MS. MUTTI: So hospitals have the choice as to
13 whether to get accredited or to be surveyed by the state.
14 And you are right, the conditions of participation are the
15 basis -- they have to be picked up in the accreditation
16 standards, but in some cases they go beyond that.

17 As I recall, something like 85 percent of
18 hospitals choose to get accredited, leaving only 15 percent
19 getting state surveyed, so there's to your implication. But
20 for nursing homes, they're all surveyed by the states, and
21 the percentage on home health and all the other entities are
22 lower than the hospitals. I'm not sure on each of those.

1 And, yes, it's envisioned here that those
2 intermediate sanctions, if certain standards are not met,
3 would have to be -- the sanctions for the failure to meet
4 those things would have to be implemented by the
5 accreditors, just as it is by the surveyors.

6 MR. HACKBARTH: And just to make it simple, let's
7 just focus on hospitals for a second. So the Joint
8 Commission accreditation process does not currently have an
9 analog to intermediate sanctions?

10 MS. MUTTI: Not that I know of. Do you?

11 MR. KUHN: Actually, I think they do. I was
12 making some notes here. They've had a tiered system for
13 decades, and it goes like this: They've got accreditation
14 of full standards compliance, conditional accreditation,
15 provisional accreditation, and preliminary denial. So they
16 have a tiered system already in existence.

17 MS. MUTTI: Yeah, I think they said that they had
18 backed off a little bit some of those criteria because they
19 had been concerned about the distinctions being as precise
20 as they would like to be. When I have talked about this
21 idea with them, bouncing it off, they were receptive.

22 MR. HACKBARTH: Okay. And then my other --

1 MS. MUTTI: We're also talking about more tools
2 than just saying preliminary accreditation. We're talking
3 about, when we talk about intermediate sanctions, you know,
4 the possibility of requiring management changes or getting a
5 little bit more involved or, you know, talking about
6 elective procedures. So those are more aggressive.

7 MR. KUHN: That was going to be one of my
8 questions as we move forward, that, you know, because
9 they've had a tiered system experience for a decade or more,
10 what are the learnings from that that would be helpful as we
11 think about our possible recommendations here.

12 MR. HACKBARTH: Okay. And then the other sort of
13 background question that I wanted to ask is about the IOM
14 report on QIOs. I know in previous months' material,
15 there's been some description of those recommendations that
16 the IOM made. But are the recommendations here now, the
17 draft recommendations before MedPAC, consistent with the IOM
18 recommendations? In particular, I'm interested in are there
19 any ways in which they might be perceived as inconsistent
20 with the IOM recommendations.

21 MS. MUTTI: They also talked about low performers,
22 didn't quite put the emphasis the sharper point that we're

1 putting on, but it's not inconsistent.

2 The second one, the idea of improving engagement
3 of providers by giving them the choice of who assists them
4 is a departure. They didn't speak against this. It just
5 didn't --

6 MR. HACKBARTH: They did address --

7 MS. MUTTI: That's the major structural. They
8 also talked about improving the variety of agents and
9 numbers. They didn't address intermediate sanctions or a
10 public recognition program.

11 MR. HACKBARTH: So no direct conflict.

12 MS. MUTTI: No.

13 MR. HACKBARTH: We're addressing some areas that
14 they didn't address, and they addressed some things that we
15 didn't address.

16 MS. MUTTI: And then there's some overlap.

17 MR. HACKBARTH: And there's some overlap. Okay.

18 Clarifying questions?

19 MR. GEORGE MILLER: Just very quickly, this was
20 very well done, and I really appreciate the work and the
21 thought process that went into it, particularly with the
22 draft recommendations, so I'll come back to that in Round 2.

1 Just one technical question. I was intrigued by
2 minority populations that would bypass -- I think you used
3 the example of New York City -- would bypass a higher-
4 quality hospital to go to one that I guess they were more
5 familiar with. Do you know what the patient satisfaction
6 ratings of the two different hospitals would be? Did you
7 get that detail? Because I'm wondering why would they
8 bypass a facility with higher quality. I'm trying to
9 understand that.

10 MS. MUTTI: I don't think that they did a patient
11 satisfaction analysis as part of that study. I think in our
12 conversations with the researchers that they were
13 speculating that these were referral patterns that were in
14 place, that the patients were seeing these doctors, and they
15 had admitting privileges to this hospital, so that's why
16 they were going by it. But that was some speculation.

17 MR. GEORGE MILLER: It would be interesting to
18 find out.

19 DR. NAYLOR: So on the first recommendation about
20 targeting low performers, first of all, just a great
21 balanced understanding of what these options are. I thought
22 it was a terrific report.

1 I'm on an IOM study committee on a learning health
2 system, and we're just getting started. But I was wanting
3 to understand -- I mean, even the high-performing systems
4 are not necessarily delivering the highest quality care all
5 the time to all the people, et cetera. So I wanted to make
6 sure that this recommendation -- and there's been some
7 thinking about, you know, learning health systems, putting
8 them all together, and really targeting the low performers,
9 but also enabling others to kind of grow and develop. I'm
10 wondering if this recommendation in any way is in conflict
11 with that. I mean, the critical need to target the low
12 performers I understand, but to have a context where
13 everybody's getting better as we're making that investment.
14 So I just wanted to make sure that that recommendation -- it
15 doesn't seem like it's in conflict, especially with the
16 second part, the community-level emphasis. But I was
17 wondering if your thinking would put it in conflict.

18 MS. MUTTI: I don't know if you want to take this.
19 I mean, there is --

20 DR. MARK MILLER: Go ahead.

21 [Laughter.]

22 DR. MARK MILLER: I think you've put your finger

1 on a philosophical question. I think it's hard to give.
2 There are definitely people who disagree, who think that you
3 should enter the quality spectrum broadly and try and get
4 movement. There are some who argue that it's the
5 intermediate performers, you know, because there's some
6 momentum, but, you know, if you just get a push, you'll get
7 bigger results.

8 I think what brings us to this -- and this is just
9 what Anne said. There was some sense that there was this
10 overlap between getting the bottom of the spectrum moved up
11 and this relationship between ethnic disparities, that in a
12 sense you could almost get some compression there as a two-
13 fer, and I realize that that's much too cavalier. And then
14 also the notion of displacing resources, that if there are
15 providers actively engaged in quality improvement, then
16 there's something there that says, well, let's go to the
17 people who seem to have no action, if you will. And, again,
18 that's too glib, too.

19 But this is truly a philosophical question. I
20 don't know that anybody --

21 MR. HACKBARTH: Yeah.

22 DR. MARK MILLER: -- except him could give you the

1 right answer.

2 DR. NAYLOR: Yeah, I mean, PPACA seems to align --
3 some of the provisions seem to align with this, the 500
4 million to hospitals with high levels of readmission getting
5 technical assistance. So I think that, you know, I was just
6 wondering if it was in conflict with that.

7 MR. HACKBARTH: Yeah. So this is a really
8 important question to raise, and I actually pushed further
9 in this direction than maybe Anne and Mark would have been
10 inclined to.

11 DR. MARK MILLER: Mark, not Anne.

12 [Laughter.]

13 DR. MARK MILLER: This has been a long internal
14 conversation.

15 MR. HACKBARTH: Anne's with me and he's --

16 [Laughter.]

17 DR. MARK MILLER: I just want to say Anne and
18 Glenn were right.

19 MR. HACKBARTH: I confess to having sort of a very
20 simple-minded way of thinking about this, not well informed
21 by, you know, the literature and all that. But sometimes
22 the mental exercise that I go through is, you know, what if

1 this were one giant integrated delivery system that I was in
2 charge of, and I had, you know, wide disparities in the
3 level of quality performance, and I had a finite amount of
4 resources to support quality improvement, what would I do?
5 Would I spread them across the whole thing or would I target
6 them on the parts of my system that are having the most
7 difficulty? And to me it's sort of a no-brainer what I
8 would do.

9 Now, you know, there may be other more
10 sophisticated ways of thinking about it, and I'm open to
11 those ideas. But that's why I pushed in this direction.

12 MS. MUTTI: And then we also wanted to acknowledge
13 that there's other federal funding that can get at the
14 broader system. There's the AHRQ money, and then there's
15 also the Center for Innovation that may choose to get more
16 of the middle and experiment with that, too. But maybe this
17 QIO money could be more focused on the low performers.

18 MR. BUTLER: So I think Anne and Mark are -- I
19 mean, Glenn and Anne are right, but -- that's okay, Mark --
20 but we'll come back to the --

21 DR. MARK MILLER: We don't have to get real
22 personal.

1 [Laughter.]

2 MR. BUTLER: You brought it up.

3 So one clarification on the Joint Commission and
4 conditions of participation. You can, having been in this
5 spot myself, not meet a condition of participation but be
6 fully accredited. So Medicare can come in and say, sorry,
7 you're not meeting this, and it doesn't necessarily have con
8 -- now, Joint Commission may be in the next day and
9 piggyback on some of it, but they're not necessarily -- just
10 because you have Joint Commission doesn't automatically mean
11 across the board you meet the conditions of participation.

12 Now, what I'm having a little trouble with is that
13 I agree with the intermediate sanctions -- well, I do think
14 we're trying to address the bottom end and how we either
15 support them or sanction them. But I'm having a little bit
16 of a difficulty kind of taking the general recommendation
17 that says you can do intermediates and what we would be
18 recommending as the criteria that that would be based on.
19 And the way we've presented the data is in the aggregate the
20 field and the institutions are not moving as far as we'd
21 like, but kind of like that last question, we don't have
22 quantifiably kind of describe that bottom end and what it

1 might look like and why it needs so much attention.

2 So I'm not exactly clear, and maybe that's okay at
3 this point. It's just the concept. You know, if you went
4 and you said you had 50 percent mortality at X or Y. But I
5 think those institutions ought to kind of get a sense of
6 what it is that might trigger the sanction, because we're
7 being pretty general about that. And, again, maybe that's
8 as good as we can get at this point in time, but ultimately
9 you're either going to have to build those criteria into the
10 conditions of participation as a prerequisite to identify
11 the institutions or just get a little bit more specific.
12 Otherwise, people could challenge, well, why me, why now.
13 And I don't know if you've thought about -- this is kind of
14 Round 2, but have you thought about how you would then
15 advise the -- huh?

16 MR. HACKBARTH: [off microphone].

17 DR. NAYLOR: It's Round 2.

18 MR. BUTLER: Well, I'll convert it to a question.
19 Is there criteria that you've thought about that would then
20 trigger, okay, you get intermediate sanctions?

21 MS. MUTTI: Right. You raise a good point. We
22 are vague on that. We haven't done that work to specify it.

1 I think ultimately it would have to be. Whether it's us
2 specifying it in this document, we can do more work to try
3 and flesh that out. But we haven't done that detailed work.
4 It might not be for us to do. But we could comment more.

5 DR. KANE: I'm interested in -- one thing that
6 struck me as I was listening to the types of problems and
7 the definitions of, you know, poor quality is that we are
8 still in our silo mentality as we discuss that. It's a
9 hospital's mortality rate or it's a skilled nursing home's.
10 And I'm wondering have you thought about both changing the
11 name of the type of provider from not just the siloed
12 providers but perhaps, you know, maybe we should be focusing
13 much more on the -- actually the community was beginning to
14 get my attention because I think maybe that's more
15 important. What are the levels of performance? So, I mean,
16 I guess, you know, what -- I'm afraid we're reinforcing
17 siloed mentality both in terms of thinking of who the
18 provider is and the -- and so I guess I'd like to get your
19 thoughts on both that and how we measure performance, which
20 is related, because you can focus on surgical outcomes or
21 you can focus on chronic disease management across the silo.
22 I think you're going to focus very differently who's

1 behaving -- who's got bad performance depending on, A, what
2 your definition of a unit of care is, and then that will
3 automatically -- so, anyway, that's kind of my first
4 question.

5 And then my second question is: Are you thinking
6 of -- notice how I made these questions as opposed to -- are
7 you thinking about just Medicare being the target population
8 or all payers? For instance, in some of the communities
9 where a lot of minorities are served, Medicare is really a
10 minor player, and it's much more Medicaid and uninsured. So
11 how limited and siloed do you want to make this as opposed
12 to broader? Is this just Medicare's technical assistance?
13 But yet if you do that, you're going to miss really, I
14 think, some of the lowest performers who really needs help.

15 MS. MUTTI: On the first, we had given a little
16 thought to the idea that -- you know, concern about being
17 too siloed as we focus on each provider, and we picked it up
18 a little bit in our discussion about what measures you use
19 to measure performance. And to the extent that you use
20 measures like readmissions or even things like emergency
21 department use or admission rates -- because we know that
22 providers collectively can influence how people are using

1 care. If we use those measures, you would be -- even if you
2 were holding a given provider accountable for it, it
3 required that they work with other providers. So that it
4 would induce some community efforts, not just something
5 within their own walls. To improve those measures, you have
6 to go out and work with other providers. So that was one
7 way we were sort of trying to lean to get away from the
8 specific silo thing.

9 On the Medicare/Medicaid, I think it's a good
10 question. I hadn't thought about that.

11 DR. MARK MILLER: Back on the first one, also
12 doesn't the community approach allow you to kind of continue
13 across some of the silos or two?

14 MS. MUTTI: Absolutely.

15 MR. HACKBARTH: Here, again, this is a really
16 important question. There are some quality problems that
17 exist pretty much within the four walls of the institution.
18 There are some that are a problem because they go across the
19 silos. And as we've discussed in many different contexts,
20 many of the most important troubling problems are the ones
21 that go across the silos.

22 The broad approach that we took here was that the

1 bulk of the resources ought to be dedicated towards the
2 within-institution problem and focused on the low
3 performers. But some piece ought to be reserved explicitly
4 for the cross-silo problems, more community problems. You
5 know, I don't think we say anything very specific about
6 exactly what those proportions ought to be, and, you know,
7 that's an important policy judgment in its own right, and I
8 don't think we have the means to think about exactly how to
9 make that split.

10 Just let me stop there. So it's an important
11 problem we tried to address. Whether we addressed it
12 sufficiently well or not I'll leave to you folks.

13 DR. CASTELLANOS: I think you probably answered my
14 question already. Maybe it's getting where Nancy didn't
15 want to go when we talk about silos. This is motivating
16 Medicare to help all Medicare providers. I want to make
17 sure that we're going to also perhaps help the physician
18 community also.

19 MS. MUTTI: Absolutely. Thank you for that
20 question because I did want to be sure that everybody
21 understood that.

22 MR. KUHN: Two quick questions. One, as we've

1 talked about this Draft Recommendation 1, we've talked about
2 the issue of ethnic disparities, but I think also a
3 reasonable measure -- and I didn't know whether you had
4 thought about this -- picking up on our conversation on
5 rural areas yesterday, one of the reasons for lower quality
6 perhaps in a rural community could be lack of a primary care
7 physician, education, poverty levels in those communities as
8 well. So I would want to think about that a little bit, or
9 if you all kind of thought of that as an option as we think
10 about this one, too.

11 MS. MUTTI: We definitely thought that certain
12 rural areas would be very ripe for assistance based on this
13 kind of targeting.

14 MR. KUHN: Yeah. And then the second question I
15 had, in the materials I had, on page 14, there was this
16 notion about the single point of intake for filing patient
17 complaints. I think the Center for Medicare Advocacy had
18 that; also the IOM recommended it back in '06. I was pretty
19 intrigued by that because I thought it raised some
20 interesting ideas about -- because there's such great
21 variation by state survey agencies and all the other
22 activities that go on. I'm just curious why, if this has

1 been a recommendation out there for several years, has it
2 just kind of languished out there? Why has there not been
3 more conversation about this and more take-up rate on
4 something like this?

5 MS. MUTTI: You know, I think I probably would
6 need to look into that more. I think there's been an effort
7 to standardize the complaint process across state survey
8 agencies, and they have made more of an effort, CMS has
9 clearly made more of an effort to increase the awareness of
10 beneficiaries that they are to go to QIOs with their
11 complaints so that there is not so much confusion as to who
12 they go to.

13 But the fact that there are still so many
14 different options for who you can go to for patients and
15 beneficiaries alike, I don't know why that hasn't been taken
16 up more broadly as a policy direction. This is sort of an
17 issue that we picked up incidentally as we were looking at
18 making technical assistance more effective and just sort of
19 stumbled on this as being perhaps an opportunity.

20 DR. BERENSON: I had two and I will pick up one of
21 them as a direct follow-up on that one, which is that as I
22 remember -- and maybe it's changed -- the QIOs not only

1 field complaints, but they do real-time appeals of hospital
2 discharges. And that's not exactly the same thing, and it's
3 a very important function, and I guess the question is: Did
4 the IOM have a recommendation as to who should do that? The
5 administrative contractors? Did they get to that level of
6 specificity? Because it may be a different solution for
7 those two different activities.

8 MS. MUTTI: Right. No, I don't believe they did.
9 I think they stopped kind of where we're stopping with the
10 idea that, you know, another entity, maybe others are better
11 prepared to figure out who that entity is to do that. But
12 the IOM recommended both that the beneficiary complaints go
13 to someone else as well as these other appeals.

14 DR. BERENSON: Okay. The other question I wanted
15 to follow up, Glenn asked about consistency with the IOM,
16 but in addition to the 10th Scope of Work, which you said
17 was due any day now, there's a Secretary's report on
18 quality, the quality strategy, which was due January 1 and
19 is due any day now, and I assume would be taking up some of
20 these issues. And then I believe there's going to be a CMS
21 patient safety report, and Don Berwick is probably the
22 single smartest person around on strategies. It makes me a

1 little nervous that we'd be issuing something and then find
2 we're outdated or irrelevant or something.

3 So what can you tell us about the timing of those
4 expected products and whether you think they'll be covering
5 some of the same territory.

6 MS. MUTTI: Timing, we also had heard that this
7 was coming, and we heard maybe yesterday or something that
8 this would be coming out. So it is supposed to be soon, I
9 believe.

10 In terms of, you know, the potential for conflict
11 here, we come out and say something, and they have a
12 different idea. The draft that did leak focused --
13 suggested that they were looking at focusing efforts on
14 reducing preventable readmissions and also hospital-acquired
15 infections. I think that is entirely consistent with the
16 bent that we're following here when we talk about, you know,
17 what are the measures for low performance? Are they things
18 like these outcomes measures? So that could be entirely
19 consistent.

20 I believe the document that I saw that was leaked
21 also made a reference to trying to marry a little bit the
22 QIO involvement and the COPs, which sounds very consistent

1 with what we're talking about.

2 The other piece that I recall was that there was a
3 real effort to see if they could get private sector payers
4 to come on board and follow Medicare's lead on payment for
5 infections and readmissions. And that obviously is separate
6 from what we are talking about here. We haven't touched
7 that.

8 Medicare's lead

9 DR. BERENSON: Which paper leaked, the quality
10 strategy or the patient safety?

11 MS. MUTTI: Patient safety.

12 DR. BERENSON: The safety one, okay.

13 MS. MUTTI: I don't know anything about the
14 quality strategy.

15 MR. HACKBARTH: So I asked the same question, Bob,
16 about how this might square with work underway in CMS,
17 because like you, I think Don is -- this is exactly the area
18 that he knows best, as well as anybody. And so what I will
19 commit to do is connect with Don and talk to him about draft
20 recommendations that we're considering, is this in any way
21 inconsistent with what you're trying to accomplish, and
22 bring that back to the rest of the Commission.

1 DR. MARK MILLER: And I guess this does go without
2 saying, but we've had several conversations with CMS about
3 this and different elements of CMS, and part of why, you
4 know, Anne can't answer everything specifically is because
5 on some of these things, they haven't -- you know, they've
6 listened politely, but also haven't given us a lot of
7 information. But Anne has made every effort to make them
8 aware of what's going on. So what's happening here today is
9 not a surprise to them.

10 MR. HACKBARTH: So my assumption is that because
11 things are in process, Don isn't going to reveal to me what
12 the patient safety strategy or the 10th Scope of Work is
13 going to say. But I think he would say, Oh, you guys are
14 just headed in the wrong direction, don't do this, this
15 doesn't make any sense.

16 DR. STUART: Bob raised the point that I was going
17 to raise -- oh, I'm sorry.

18 MS. HANSEN: Sorry. I was just going to wait for
19 Round 2, but just as a point of information on the patient
20 safety strategy, one of the things I do know is that the
21 business community has already gotten the leak as well, too.
22 So this is going to be kind of a 360 effort from all

1 different sectors.

2 DR. STUART: I won't repeat what Bob said. Those
3 were my issues as well. But do we have any sense in terms
4 of whether the 10th Scope of Work will make any of the kind
5 of structural changes that you've suggested here in terms
6 of, you know, whether other competitors would be involved
7 specifically?

8 MS. MUTTI: Actually, law prevents them from doing
9 those changes. The only one of these recommendations that
10 affect QIOs that they could do administratively is the
11 first, focusing resources on low performers. But the
12 competition they cannot -- but that goes right to the point
13 that in the President's budget there is a request for
14 legislation that would change that to increase competition.

15 MS. UCCELLO: A quick question. In thinking about
16 how to direct the money, do we have any information on
17 whether the gap in quality between low performers and high
18 performers has been widening or narrowing over time?

19 MS. MUTTI: I don't think we're aware that it is
20 one way or the other, but we can definitely double-check
21 ourselves on that.

22 DR. DEAN: On the issue of recognizing high

1 performers, is there any real evidence about what impact
2 that has? As I think about it, it could be either on the
3 public's decision about where they seek care, which is
4 probably the most obvious thing, or it might have an impact
5 on the performers themselves, just a motivation to keep
6 doing it. I guess I'm thinking about our own local
7 situation. Our hospital has been recognized several times
8 by Press Ganey, the big national survey firm, for patient
9 satisfaction in our emergency room. And this got lots of
10 publicity in our local paper and all that sort of stuff. I
11 think the average person on the street, if you ask them
12 today, would have no idea about that.

13 I don't think that -- we would assume that it
14 makes a difference in terms of people's decision about where
15 they seek care. My impression is that it's not nearly as
16 effective as we might assume it is. On the other hand, I
17 think that it may have an effect in motivating the
18 professionals, the providers themselves to make -- I don't
19 know. Is there any data about that?

20 MS. MUTTI: In general, I think the findings are
21 very consistent with what you're thinking, that the public
22 disclosure of performance tends to really be digested by

1 providers themselves, and their professional pride kicks in,
2 and they want to demonstrate and get better, and that the
3 consumers are not using it.

4 The one part that I don't know so much about is,
5 you know, these kind of marketing campaigns where it's on
6 every billboard or draped across a banner in front of the
7 hospital. That kind of promotion, I'm not sure if I know of
8 the data on whether that's effective or not.

9 MR. HACKBARTH: Okay, Round 2 questions or
10 comments?

11 MR. GEORGE MILLER: You want us to comment now on
12 the draft recommendations.

13 MR. HACKBARTH: Yes, thanks for the reminder.
14 Since we have draft recommendations, it would be helpful for
15 me to hear from people whether you support them or what
16 reservations you have. And not everybody needs to speak.
17 If you're just comfortable, I'll assume silence means
18 assent. Karen, is that a valid assumption in your case?
19 Okay.

20 DR. BORMAN: [Nodding head.]

21 MR. HACKBARTH: Okay.

22 MR. GEORGE MILLER: Just in general, I do support

1 all of the recommendations. I really like the direction
2 that they're going in, but I think Peter brought up an
3 important question, and I just wanted to echo particularly
4 about Draft Recommendation 1. One of the things we just
5 have to be careful of is to make sure we hit the right
6 targeted population and do it correctly, part of the
7 philosophical discussion that you mentioned, just with that
8 caution. Otherwise, I do support the draft recommendations.
9 I'm particularly pleased that we're also trying to deal with
10 disparities, and this does take a step in that direction.

11 DR. BAICKER: I really like the tenor of the
12 recommendations, and I also thought Nancy's point was
13 important, to be thinking across silos as much as we can
14 flavor that in with the recommendations.

15 MR. GEORGE MILLER: Right.

16 DR. NAYLOR: I also really support them, but would
17 recommend considering bundling them because I think focusing
18 technical assistance -- if we end up with focusing technical
19 assistance on low-performing providers without increasing
20 competition and positioning those agents with technical
21 assistance, you know, whatever, I think we won't have
22 accomplished as much. And so I don't know if this is even

1 possible, but I have some wording that would suggest
2 combining 1, 2, and 3. And then number 5 I really like, but
3 I also wonder is public recognition going to be enough. You
4 know, is there a way to think about kind of these stretch
5 performance expectations for which they get stretch -- not
6 just kudos but real recognition and reward? And so that was
7 just a consideration.

8 MR. BUTLER: So I think we're being pretty bold in
9 support. I think it's because we're not moving any money
10 around.

11 [Laughter.]

12 MR. BUTLER: Or not as much as we usually would.
13 I'll make up for my Round 1 behavior and say I support the
14 recommendations. I like them, with one exception. I think
15 I'd say two things about. One is that I think consumer-
16 driven social media kinds of activities are going to trump
17 all of these recognition things in terms of driving consumer
18 behavior.

19 Having said that, I would support the public
20 recognition using the Hospital Compare. I think adding
21 another set of metrics with one more scorecard for providers
22 to chase at this point would not be a good thing. We've got

1 enough set of things to run after, and I think that the
2 value-based purchasing, which really starts this July, in
3 effect -- because how we start performing against the
4 measures on HCAHPS and the -- really starts the nine-month
5 cycle or something. It's this July. You'd get far more
6 bang out of your buck expanding that more quickly and
7 putting more dollars at risk in terms of focus than simply
8 adding an additional set of measures that would be publicly
9 reported. So I don't support the addition of additional
10 measures as part of the recognition system.

11 MR. HACKBARTH: So let me just ask a question,
12 Anne, about what you envision would happen. I guess I was
13 assuming, maybe too quickly, that we wouldn't be talking
14 about a whole different set of metrics, that we would be
15 applying existing metrics to develop this designation. So,
16 you know, the metrics in hospital value-based purchasing as
17 opposed to giving you another set of targets to shoot at,
18 I'd say let's take those and use them to create the
19 recognition program. Is that what you envision?

20 MS. MUTTI: I understand what Peter's responding
21 to because I was allowing for the possibility that you might
22 want to have a recognition program that builds on Hospital

1 Compare, but also picks up some of the things that we're
2 going to get caught in in the survey, which might include
3 the hand washing or the discharge planning.

4 MR. HACKBARTH: Right, right.

5 MS. MUTTI: You know, that kind of thing.

6 MR. HACKBARTH: Got it. Yes.

7 MS. MUTTI: But that was thrown open for
8 discussion.

9 MR. BUTLER: So I would rather have those kinds of
10 things put right into the payment system when they're ready
11 as opposed to being flagged. And then you might even change
12 your mind whether those are important and when they're
13 eventually put in the payment system. Meanwhile, we're --
14 but if you want to put big huge stars next to the Hospital
15 Compare stuff so you highlight them in different ways above
16 and beyond just making -- that's fine.

17 MS. MUTTI: Yeah, a raw number or something.

18 MR. BUTLER: That's good. Can't hurt.

19 DR. KANE: I'm very supportive of the notion that,
20 you know, we should more efficiently target these technical
21 support resources. I think in defining performance,
22 however, I would like to have at least Medicaid and Medicare

1 metrics involved, not just Medicare alone, particularly so
2 that you can pick up some of the communities I think that do
3 serve lower-income and minority beneficiaries and have less
4 Medicare but a lot of Medicaid and people who are more
5 vulnerable. You know, if you're thinking these are really
6 public resources, they should help public patients, both
7 types.

8 I think on Recommendation 4 about sanctions, I'm
9 all for sanctions, but I think we should -- the one that
10 said, you know, suspend or prohibit elective procedures,
11 that makes me very nervous. That could really have a long-
12 term negative financial impact. So maybe if you're going to
13 do something like that, you should try to have some modifier
14 that whatever intermediate sanctions are there, are there to
15 primarily address directly the poor performance but not
16 generally damage the place financially just for the purpose
17 of being, you know -- it shouldn't financially damage them
18 because that could really damage an institution that's
19 struggling. But certainly replacing the management and/or
20 the board or not allowing performers who have very bad
21 outcomes to continue to operate or whatever, that's okay.
22 But I think generally you don't put things in there that are

1 going to really damage the long-term survivability of the
2 institution. So, otherwise, I'm very supportive of all the
3 recommendations.

4 MR. HACKBARTH: A question about the
5 Medicaid/Medicare issue. Are you suggesting that in
6 evaluating performance we ought not just use Medicare data?
7 Or are you suggesting that a different set of measures be
8 used to reflect the issues in caring for the Medicaid as
9 opposed to Medicare population?

10 DR. KANE: Well, I think things like readmissions
11 or hospital ER use, inappropriate hospital ER use, or
12 ambulatory care center conditions, those kind -- I think you
13 want to look at the low-income population in particular.
14 That's where a lot of the poor performers might be located.
15 And Medicare patients don't often use those providers. You
16 know, if you look across the spectrum of where are the real
17 safety net hospitals, Medicare is less than 10 percent
18 sometimes. But there's a serious problem going on.
19 Medicare patients do use them, but the much bigger groups
20 are these other populations. And I think if you are going
21 to define low performers just on Medicare definitions,
22 you're going to miss a lot of the really lower performers, I

1 think.

2 So I'm just saying if you could get -- and there
3 are all-payer data sets and just pull out the Medicare and
4 Medicaid --

5 MR. HACKBARTH: In some places, yeah.

6 DR. KANE: In some places. And certainly this is
7 another example where we should be sharing with Medicaid,
8 you know, their claims or whatever data they use to -- and
9 put them together and say, okay, well, this particular
10 neighborhood has terrible providers, and a lot of it it's
11 going to be picked up because of the Medicaid data, not the
12 Medicare data.

13 MR. HACKBARTH: Okay.

14 DR. MARK MILLER: The only thing I would say is in
15 the extreme, if somebody took your thought to the extreme,
16 you know, are we saying that this money would go to -- let's
17 just pretend the hospital has no Medicare? Because then,
18 you know, we've really just taken trust fund dollars and
19 sent it off to a very different function. And the way I
20 would try and square the reasonable question that you've
21 raised is that there is this portion that is devoted to
22 community, and certainly thinking about the community

1 broadly in that context I think makes sense. But in the
2 extreme, if you're saying that this is driven off of, you
3 know, uninsured, Medicaid, or those populations, you could
4 be shipping dollars to a hospital that doesn't serve any
5 Medicare. And then I think you've really taken this
6 function and this money and the trust fund dollars and
7 headed in a very different direction.

8 DR. KANE: I'm not suggesting no Medicare
9 patients, but they are often not the 30 percent they usually
10 are. They're much smaller. And they may be -- I mean, it
11 may show up in the Medicare data, but I think it's more
12 likely you're going to see poor performers when you look at
13 the broader payer mix. It's the provider that's --

14 MR. HACKBARTH: Implicit is the premise that you
15 might get different results for the small Medicare
16 population in these safety net hospitals than you get in the
17 Medicaid. And they could look fine on Medicare, but be --

18 DR. KANE: [off microphone] Okay. They might be
19 okay, but if you really look at the broader provider
20 performance, they're really low-performing. And it could
21 only help -- also, Medicare performance, you still always
22 know -- you know, you're looking at three conditions. And I

1 think you might pick up more variability if you try to
2 expand them a little bit through some of these other
3 metrics. But I don't have the technical answer.

4 MR. HACKBARTH: Yes.

5 DR. CASTELLANOS: In the context of Medicare's
6 role of motivating and supporting quality care, I'd like to
7 go in a little different direction, and I recognize there's
8 a tremendous threat to me to get tarred and feathered by the
9 medical profession. But I'm going to take Bob Berenson's
10 approach. I'm going to call a spade a spade.

11 [Laughter.]

12 DR. CASTELLANOS: I'm going to call a spade a
13 spade, and sometimes I'm going to call it a shovel.

14 The question here is, if you remember, in the
15 November panel discussion with Chris and Bob Wachter, they
16 had a great quality and outcome thing, and the question I
17 asked them was -- there was no discussion on
18 appropriateness, and Bob Wachter's answer was, "You're
19 right." And we've talked about clinically appropriate
20 guidelines, and I've kicked this can down the road for so
21 long, I would really like to try to see if we continue to
22 kick it and do something.

1 What do I mean by clinical appropriate guidelines?

2 Well, Nancy brought up a subject yesterday. She said the
3 cyberknife for prostate cancer. It's a very appropriate
4 treatment. There's good quality. There's not a lot of data
5 on it. But is it appropriate to treat everybody that way?
6 No. Sometimes we treat it just by observation, and
7 sometimes, as you and I talked yesterday, IMRT, but there's
8 a lot -- and what the societies need is help in developing
9 appropriateness criteria.

10 I can tell you, I've had discussions with my
11 society on it, and it was very interesting. I had a very
12 pretty negative approach by the physician community on the
13 Health Policy Council, but the staff of the Health Policy
14 Council came back to me and said, you know, you're right.
15 We can use some help. We can use help getting the data. We
16 can use help developing some of these criteria.

17 Now, I recognize it's going to cause a lot of
18 uncomfortableness in the medical community, but we really
19 need to start looking at appropriateness. What's
20 appropriate?

21 You know, here we're starting to talk about
22 comparative effectiveness and stuff like that, and I would

1 like to see where perhaps not with the QIOs but perhaps with
2 AHRQ or PCPI where there's money set aside for societies who
3 are willing and able to go ahead and recognize maybe we do
4 have a problem with appropriateness criteria.

5 Now, how vulnerable is that? Well, our society
6 said that. I had a very brief talk with Karen about this
7 two months ago, and as she was walking out the door, she
8 said, well, you know, that's something that maybe general
9 surgery would be interested in, and I talked to the AMA, and
10 they've had other societies come to them asking for help in
11 doing this.

12 So instead of continuing to kick this can down the
13 road, I would like to try to see if we can somehow establish
14 a role in motivating and supporting development of
15 appropriateness criteria.

16 MR. HACKBARTH: I think Ron is making a good point
17 that maybe our title is too broad for this. There are a lot
18 of things beyond QIOs that Medicare can do to motivate and
19 support quality improvement, and I'm with you, Ron. I would
20 consider issues of appropriateness quality issues as well as
21 cost issues. And so we may need to think about how we title
22 this, but also some of the text that leads into the QIO-

1 specific discussion to make the point that the quality issue
2 really is broader than what we're talking about here. It
3 covers issues in payment policy. It covers issues -- you
4 know, I think an important thing that the government is
5 starting to do to support the development of guidelines is
6 the investment in comparative effectiveness research, a huge
7 investment that will provide raw material, hopefully, to
8 inform evidence-based guidelines.

9 So I think to get into the guidelines issue,
10 appropriateness issue in this particular chapter would take
11 it in a whole new direction, and so I'd like to see us, you
12 know, narrow the title, do some appropriate lead-in to
13 suggest that there are many other issues in quality than
14 just this. But this chapter is focusing on QIOs. And, you
15 know, let's talk about the appropriateness issue in a
16 different place, and let's you and I talk about how to take
17 that up.

18 MR. KUHN: A couple quick things here. One, to
19 kind of revisit the issue of COPs, and I think we're missing
20 an opportunity by not putting forward a recommendation in
21 this area. And I've shared before with the Commission that
22 a number of the COPs right now continue to reinforce the

1 silos that we have in health care out there. I've talked
2 about ones dealing with discharge planning, for example,
3 right now where you need to report it within 30 days, and
4 how is that going to fully support a 30-day readmission
5 policy as we go forward.

6 I've heard of ones recently dealing with drug
7 dispensing in hospitals, where you need to dispense the drug
8 within 30 minutes, and so hospitals, in order to deal with
9 adverse drug events, issues like that, have started to buy
10 new technology, these carts that help in the dispensing to
11 try to get it down to zero defects. The interesting thing
12 about those carts is that they time and date stamp when the
13 drug is dispensed, and if it's 31 minutes, hospitals across
14 the country are now being written up as violating the COPs
15 as a result of that. So what nurses are doing, they're
16 doing the work-arounds. They're opening the carts, they're
17 taking the drugs out, which could lead to safety issues as
18 we go forward.

19 So I think the COPs are in bad shape, and I'd like
20 to see us think about a recommendation where we would
21 perhaps ask the Secretary to evaluate -- you know, do a
22 pretty thoughtful evaluation of the COPs and think about an

1 ongoing effort to update those to meet the new standards of
2 care plus to really support the new payment delivery models
3 that are coming forward. I think that's a troubling area
4 that I'd like to see us go back and look at.

5 On the other recommendations, I think the first
6 three make a lot of sense. I think the fact that we will
7 strengthen -- I think we'll strengthen the process through
8 those, and I think those work very well.

9 On the issue of enforcement, I'm kind of torn on
10 this one, and when Anne kind of described it in terms of
11 kind of the intermediate sanction opportunities -- because
12 as everybody in health care knows, that's kind of a death
13 penalty. You know, there's no chance for intermediate
14 sanctions, and I think even CMS and surveyors struggle with
15 that because they see a violation but it doesn't warrant
16 kicking someone out of the program. But that's the only
17 option they have.

18 So when you kind of described it that way, it made
19 sense to me. But when I see the recommendation, it doesn't
20 translate that way in terms of what I thought we were trying
21 to achieve there. And the reason I'm a little troubled by
22 this and I want to think about it more, Glenn, is the fact

1 that if you look at what's in PPACA now, there are some new
2 payment issues, whether it's readmissions, hospital-acquires
3 conditions, things like that, where there are going to be
4 payment penalties now as a result of that. And the way
5 those payment penalties work, it just kind of hits the lower
6 quartile of certain providers out there. And some people
7 are very concerned that that might be a self-fulfilling
8 prophecy here that these providers are going to continue to
9 get dinged in terms of their payments and are they going to
10 be able to catch up. And then if you layer a sanction on
11 top of that, are we just driving them to the bottom on a
12 regular basis? So I'd like to kind of think that one
13 through a little bit more. And the fact that the Joint
14 Commission has had a tiered process for so long, I kind of
15 want to understand how these sanctions will interact with
16 the new payment policies, which will be putting penalties on
17 there as well. And will that help support that effort or
18 will that continue to drive people to the bottom? I don't
19 know. I want to think that through.

20 Then, finally on the -- I'm sorry.

21 MR. HACKBARTH: On that issue, Herb, what I hear
22 you saying is that in some ways with the new payment

1 policies and financial consequences to poor performance on
2 certain measures, there is, in fact, a type of intermediate
3 sanction already.

4 MR. KUHN: Already as a result of that. I think
5 the payment policies do drive that, and so that's why I'm
6 wondering if this is more towards low performers, or is it
7 something to give CMS a more robust tool kit in order to do
8 gradations that are out there.

9 MR. HACKBARTH: Yeah. Now, one issue is that
10 although, as you say, PPACA started down this path, they're
11 very focused on particular problems, like surgical infection
12 rates and readmissions as opposed to broader quality
13 problems.

14 MR. KUHN: Right.

15 DR. MARK MILLER: You know, I think the way these
16 things come together -- and I do see -- just divorce the
17 thought for a second of do the payment policies effectively
18 capture the intermediate sanction thought. Just let me hold
19 that aside for a second.

20 I think the thinking here works like this: There
21 is a recognition in PPACA that there were certain penalties
22 for certain kinds of, you know, readmissions, hospital

1 acquired, and a concern that if a provider is driven into
2 the basement and stuck in the basement with those penalties.
3 And that's in a sense what I think motivated a lot of this,
4 this notion of focus the resources on those providers, give
5 them a renewed flexibility to go after their specific
6 problems in some measured way, you know, time-limited way.
7 And then if they can't turn the operation around, then maybe
8 that is an indication of a problem, and I think that's where
9 the intermediate sanction thought comes in. But you're not
10 bouncing the person entirely from the program, but the
11 notion of trying to graduate them through it.

12 But I think some of the motivation was
13 specifically to keep a provider or give at least a provider
14 who might end up in the basement and not ever able to get
15 out of the basement the chance to come up. And I think
16 that's why it's focused on the low performers and trying to
17 put the money right in their lap and saying find the
18 problems that are driving you into the basement, work with
19 an array of providers. At least that was some of the
20 thinking.

21 But, nonetheless, you've made the point that there
22 is an overlap here between some of the payment policy and

1 intermediate sanction, and we can at least think that
2 through.

3 MR. KUHN: That's helpful, Mark, both what you and
4 Glenn shared helped.

5 DR. MARK MILLER: Sorry it went long.

6 MR. KUHN: Finally, on the high performers, I'm
7 just curious. It makes sense to me. I think we all know it
8 will probably, you know, help the outdoor advertising
9 industry in terms of more billboards and things like that.
10 But I'm curious right now. Within the Medicare program,
11 you've got a star rating system for skilled nursing
12 facilities, a five-star rating system. You have a five-star
13 rating system for MA plans. In fact, as part of PPACA, that
14 star rating system now is triggering a bonus payment to MA
15 plans. So it has been in effect already within the Medicare
16 program. Has it been an effective tool? You know, how does
17 this differentiate from what Medicare is already doing now
18 is kind of my thought on that one.

19 DR. BERENSON: First, let me just address Ron's
20 issue, and I will protect you with the medical profession.
21 I think, as I said yesterday, that the lack of -- the
22 inability to address appropriateness is to me the Achilles'

1 heel of episode-based payments, and we need to work on it.
2 I think it belongs on a different timeline and a different
3 context, but it's very important and I think it's something
4 we should take up. And so we may need some title issues
5 here.

6 I wanted to pick up just where Herb had left off
7 on the last recommendation. I had a different notion,
8 especially in the slide when you talked about superior
9 quality, that it would be something more like an award given
10 to one, maybe even one but maybe a couple of organizations a
11 year, as prestigious award. Part of my thinking is that I
12 actually don't think that performance measures that are
13 currently in use and, in my view likely to be in use for the
14 foreseeable future capture more than a relatively small part
15 of an institution's commitment to quality. And we do, as
16 Herb said, have -- it's part of the sort of momentum is that
17 we are going to have ratings and we'll see how that affects
18 public behavior. I mean, that's part of the system anyway.
19 So my idea -- and this is just off the top -- was that --
20 what's the name of that award that people strive for?

21 DR. KANE: Baldrige.

22 DR. BERENSON: Baldrige, yes. The Baldrige Award.

1 It would be some kind of equivalent of that which actually,
2 I think, organizations would probably apply for and tell a
3 review panel what they are doing. They clearly have to meet
4 the high levels on the performance metrics, but in addition,
5 they present their sort of institutional commitment that
6 captures culture and leadership and management, and the two
7 are not mutually exclusive by any means. But I wonder
8 whether we should give some thought to that kind of an
9 approach as well.

10 So, you know, obviously it's in the interest of
11 organizations to win that award. They have media around
12 them. That's something that's not awarded to a hundred or a
13 few hundred organizations. And you can one year pick the
14 one that's about care coordination across silos and say --
15 and, again, I don't know if it should be one or it should be
16 ten, but something really superior that goes beyond just
17 using performance metrics. And I agree with Peter. We
18 don't just want to create a whole new set of performance
19 metrics because I don't think that gets us where we want to
20 go.

21 MR. HACKBARTH: That's helpful. It's a way of
22 distinguishing.

1 MS. HANSEN: I just want to say first off thanks
2 to Anne for the chapter. I think you wove in a lot of the
3 previous work, and some of the issues of safety with our
4 presenters this last fall.

5 I am very supportive of the direction of the
6 proposals, and I appreciate the focus on kind of the high-
7 risk performers who don't want to necessarily, of course, be
8 in that category, but oftentimes are in that circumstance
9 with comments made by other folks on the other side of the
10 table.

11 My one concern from another dimension of the
12 fourth recommendation relative to the punitive side is that
13 oftentimes people who are already at the bottom, the ability
14 to get up, so to speak, takes not just a small amount of
15 time. It's a huge change because there are many variables
16 that aren't easily just controlled by having a board look
17 at, you know, their performance and all.

18 So I just wanted to be cautious about the
19 unintended kind of potential consequence -- I think maybe
20 Herb said, you know, it almost becomes a way to get
21 reinforced at the bottom, even though the intent was really,
22 frankly, the opposite, because there's enough work that's

1 gone ahead. The National Academy of Social Insurance just
2 spoke about how health disparities persist despite the fact
3 that people have coverage under Medicare. So, you know,
4 it's not so straightforward as a performance improvement
5 program. So I just wanted to make sure that that group
6 getting assistance will actually get a risk-adjusted
7 consideration of how it gets to move along the line of
8 improvement. So it's certain considerations of that crowd,
9 because oftentimes the absolute safety net of a given
10 community would some degree of Medicare population, but they
11 tend to always get a rough piece of this.

12 The other point of information that I know the
13 American Hospital Association has had some work in this
14 whole area of disparities moving along, and they have
15 renamed its committee Equity of Care Committee. That's
16 going to be focused specifically on closing the gap of
17 disparities. So there is some work, I think, by the AHA to
18 deal with this. But, again, good intention, support this,
19 especially with the more high risk population, and getting
20 it from providers who will understand the nature of the
21 issues of improvement that are not mainstream issues.

22 DR. STUART: I strongly support the

1 recommendations, and I think this chapter deserves a five-
2 star rating.

3 [Laughter.]

4 DR. STUART: And there are a couple of things that
5 I'd add. I think that this is touched upon every
6 Commissioner's interest. I think we're all interested in
7 this, and so there's a sense of kind of piling on to make
8 sure that our particular interests are covered here. And
9 one way that we might be able to address that is maybe the
10 title is something, but I think it would also be useful to
11 have a schematic that says, okay, well, here are the things
12 in this large domain that we're going to focus upon here
13 that we think are important, and we want you to keep those
14 things in mind as we go through this and not be distracted,
15 but not to suggest that we are, in fact, ignoring the
16 others. It's just that we are going to be signaling that
17 those are going to be picked up at another point in time.

18 The other thing that I think is a bit awkward
19 about this chapter is the fact that we've got these three
20 major reports that are going to be coming from CMS, and on
21 the one hand, obviously we're not a toady for CMS. We're an
22 independent agency and, you know, we say what we think. On

1 the other hand, there's a real opportunity here if there are
2 things that we agree with to support those and to double --
3 you know, to give a strong appreciation for what CMS is
4 doing. And so I'm thinking that over the next -- well,
5 we've got about six weeks between now and the next meeting.
6 And to the extent that any of these reports are released, if
7 you could make those available to the Commissioners, I think
8 that would be really helpful. And if it turns out that
9 maybe there's something that we would even want to postpone
10 a formal vote on or at least to consider after the April
11 meeting but before -- and I recognize the timelines are
12 tough here on publication, but at least to do whatever we
13 can in our power to make sure that we are building upon the
14 strengths that we perceive when they come out in these
15 reports.

16 MR. HACKBARTH: Our time is short, not just
17 because the April meeting isn't all that far away, but also
18 because of production issues that we have.

19 Having said that, you know, I will talk to Don and
20 make sure that we're not at cross, or if we are at cross
21 purposes that you folks know that when we talk about what
22 the areas of agreement and disagreement might be, and then

1 we can act accordingly in April.

2 The patient safety initiative, do we know if
3 that's going to be something that comes out and is subject
4 to some sort of a public comment period? Because that is
5 another avenue for us to say, you know, go, CMS, you're
6 doing great things. I just don't know what kind of a format
7 that's going to come out in. It doesn't --

8 MS. MUTTI: Yeah, I don't know either. It may be
9 like a broad rubric pulling together a bunch of different
10 its, like the 10th Scope of Work, like some COP reform that
11 I think they're planning on anyway, and sort of pulling it
12 together and announcing the cooperation with the private
13 sector. In that case, maybe there's not a specific comment
14 on that, different pieces.

15 MR. HACKBARTH: But even if there isn't a formal
16 public comment opportunity, we could do, as we did on ACOs
17 where we plan to just write a letter, you know, this is an
18 area of interest to the Commission and, you know, we want to
19 applaud these particular aspects of the initiative.

20 So we've got two objectives here. One is that we
21 don't, you know, run at real cross purposes with them, and
22 I'll try to track that down with Don. And then second is we

1 have various avenues that we can use to support CMS if we're
2 so inclined.

3 MS. BEHROOZI: We hate silos and we love
4 integration, so I just want to comment that this is a great
5 integration of previously siloed areas of analysis, and
6 particularly, obviously, the disparities research and
7 quality. So I think the recommendations are great, and I
8 support them, and I just have a couple of comments.

9 With respect to Recommendations 1 and 2 -- and 3,
10 I guess -- or 3 in particular, eliminating the unrealistic
11 barriers to participation in the QIO program sounds great,
12 but, you know, going from a highly regulated sort of static
13 kind of situation to a market situation carries it's own
14 perils. And, you know, I'm just sort of envisioning a post-
15 transition landscape with every consultant in the world,
16 many of whom we know and many new ones who will pop up on
17 the scene, you know, flooding providers with, Oh, oh, we can
18 help you. And we're talking about providers who are low
19 performing, and as you identify in the paper, that might be
20 because of ineffective leadership. So I think we need to be
21 very cognizant of the fact that those leaders who need help
22 might need help figuring out who the right consultants are.

1 And so I think that we need to -- we probably should
2 reinforce in Recommendation 3 that while we're removing the
3 barriers, there really still should be high standards and
4 some kind of limitations around those entities that are
5 eligible to participate in the program. And in the paper
6 and on Slide 7, you talk about CMS could create an online
7 marketplace to provide some structure and protections, and I
8 think we should kind of beef that up, talk about that being
9 a really robust tool, also with guidance about how to select
10 among, you know -- well, qualified entities but still
11 probably a much broader range of entities.

12 And then also on Recommendation 1, if we're going
13 to say the remainder should be targeted to community-level
14 quality improvement, I think we should be more explicit
15 about what we mean by that. I think what I saw in the paper
16 that referred to that was one paragraph that talked about
17 certain geographic regions are persistently low performing,
18 but we also know that within geographic regions you have
19 high and low performers. So what does that mean? Does it
20 mean we would distribute the rest of the money to all the
21 providers in a region, or that we would encourage using the
22 money for coordination efforts among providers? All of the

1 above? I think we should flesh it out a little bit if it's
2 going to be in the recommendation.

3 MR. ARMSTRONG: So briefly I just want to affirm I
4 support the direction we're heading with these
5 recommendations. Bruce did a great job of making the points
6 I wanted to make. In fact, he made them better than I could
7 have, so I thought that was a five-star comment.

8 [Laughter.]

9 MR. ARMSTRONG: I just do think, though, that with
10 this context, you know, what are all the different ways in
11 which quality is being advanced. It would really help us
12 then to be more specific about how far we want to push some
13 of the specific components within this one piece. And so to
14 the degree we could map that out in some way, I certainly
15 would learn a lot, but I think it would help us deal with
16 many of the issues or concerns that were raised in this
17 conversation.

18 DR. DEAN: I, too, support the direction of the
19 recommendations and basically support the individual
20 recommendations. I have some caution about the difficulties
21 of identifying low performers in very small volume
22 facilities because of the whole small numbers problem and

1 the challenges that that presents. In my particular state,
2 we've got about 50 hospitals and 40-some are critical
3 access.

4 That doesn't mean that they shouldn't be
5 scrutinized. They absolutely should. And it's just tough
6 to make that decision, and I just put out that caution.

7 I really think that it is important to broaden the
8 perspective on the causes of low performance because there
9 are many, many different causes, and some of them are
10 relatively simple technical things and some of them are deep
11 cultural things. And some of them you can bring in a
12 consultant and they can show a few techniques to do some
13 measurement or whatever, and you can solve the problem.

14 Unfortunately, that's probably the exception, and
15 the more common thing is traditions and cultures and things
16 that have developed over time. And those certainly need to
17 be addressed.

18 I was bothered a little bit in Recommendation 2 by
19 the phrase "time-limited technical assistance," although I
20 certainly understand why that's in there, and there is
21 obviously a limit to what can be done. On the other hand,
22 some of the changes that I know need to take place in some

1 of the facilities I'm familiar with are just simply not
2 going to change very fast. They can change and they need
3 attention and they need to be pushed and they need help. On
4 the other hand, it just is not something that's going to
5 change very fast. So I would -- I don't know exactly how to
6 rephrase that, but just with the caution we need to be a bit
7 flexible in how we look at that.

8 I guess that's the biggest part of it. I mean,
9 clearly this is a direction that we need to move and we need
10 to support and emphasize. As in so many other aspects of
11 health care -- and it's particularly true in -- the smaller
12 the community, it is so incredibly dependent on local
13 leadership. And where local leadership is there these
14 problems tend not to exist. And where local leadership is
15 weaker they are very difficult to change.

16 And so I guess I'd just say we need to recognize
17 that and be sure that we take that into account in terms of
18 any kind of sanctions and so forth. That doesn't mean that
19 -- you know, sanctions may well be appropriate in some
20 cases.

21 I guess just the other approach, I think we need
22 to do everything we can to try to keep it in a positive vein

1 because so much of what we on the front lines encounter in
2 terms of regulatory enforcement is much more of a punitive
3 kind of approach, and that engenders pushback and then
4 things don't move forward.

5 So it's hard, and a lot of times it starts out at
6 the upper levels with a very positive approach. But when it
7 sort of filters down to the actual implementation at the
8 individual facility level, it sometimes deteriorates into
9 much more of a punitive approach. So I don't know. I'm not
10 sure how to solve that, but I think we need to keep it in
11 mind.

12 MS. MUTTI: I think one thing we were trying to
13 allow for in our outline of intermediate sanctions is that
14 it doesn't necessarily have to be a monetary penalty here.
15 We could be talking about helping to change the management
16 so that if the problem is leadership, you know, we don't
17 have to financially penalize the facility. We can work with
18 the board to get management changes so that we can get the
19 quality that would otherwise be very hard to reach.

20 DR. DEAN: [off microphone].

21 MR. HACKBARTH: So I just wanted to underline what
22 Anne was saying, and whether intermediate sanctions are the

1 best tool, the right tool, I'm not sure. But there is this
2 dilemma that both Mitra and Tom have touched on. What if
3 the problem begins at the top? And, you know, how do you
4 create the impetus to change there. If the problems at the
5 top, they may not effectively use technical assistance, they
6 may not be moved by penalties on their hospital value-based
7 purchasing metrics, what can the program do to resolve
8 problems at the top? And part of the concept, as Anne says,
9 is maybe that's a role for intermediate sanctions.

10 If people have other ideas as to how to deal with
11 problems that begin at the top at the executive board level,
12 you know my e-mail address.

13 [Laughter.]

14 MR. HACKBARTH: Thank you, Anne. Well done -- oh,
15 Peter.

16 MR. BUTLER: Just one more comment, because I was
17 going to do what Herb did, and that is, suggest the
18 conditions of participation be a recommendation. I think
19 whether it's intermediate sanctions or whatever it is, if we
20 have outdated, out-of-sync conditions of participation, you
21 can't kind of go in and say here's what you got to do, and
22 you don't even have good -- you know, so I do think that

1 would be a nice addition to the recommendations.

2 MS. MUTTI: We debate that internally and weren't
3 sure that we had a specific enough one to come forward with,
4 but if you feel that way, we can --

5 MR. HACKBARTH: Okay. All right--

6 DR. MARK MILLER: I guess the only thing I would
7 say is that what I have my doubts about is whether we would
8 have enough precision to delineate at this point. So I
9 think the recommendation would have to be fairly directional
10 in general to ask for the Secretary to do something rather
11 than us coming up and saying, okay, here they are. I mean,
12 unless Anne's going to do -

13 MS. MUTTI: That's why we were hesitant because we
14 could not be more specific, oh, should it be on hand washing
15 or discharge planning or, you know, national patient safety
16 goals. You know, what specifically do we want to tell them
17 to update? We didn't feel like we were quite there yet, but
18 there could be something --

19 MR. BUTLER: And I'm not sure we're the best to do
20 it, but this would be a good Berwick question. If he says
21 that little nudge is all I need and we would have a good
22 idea of how to draft these, then we've done our job.

1 DR. MARK MILLER: [off microphone] -- aware of,
2 you know, that we could say here's the list. That's what
3 gave us pause.

4 MR. HACKBARTH: Good. Anne, thank you.

5 We'll now have our public comment period, albeit a
6 very limited one because of our time constraints, and I
7 apologize for this, but Commissioners have plane
8 reservations.

9 So we have one person at the microphone. Anybody
10 else? We'll have two people. I'm really going to have to
11 limit you to two minutes each. So when this light comes
12 back on, you're finished.

13 Please begin by identifying yourself and your
14 organization. Thanks.

15 MR. KETCH: Good morning. I'm Todd Ketch, the
16 Executive Director with the American Health Quality
17 Association. I represent the Medicare quality improvement
18 organizations.

19 Just a quick note on some of the discussion here
20 around competition. In this contract, what we know so far
21 is that there are actually six contracts that are going to
22 be fully competed in this round of competition out of 53.

1 Sometimes there are more than that. It just depends on how
2 the organizations perform under the criteria that they have
3 to meet for their evaluation. But, in fact, those criteria
4 are very, very strict, and when the government sees that
5 there's an opportunity to continue a relationship with an
6 organization, they have an opportunity under the statute to
7 renew that contract with that particular organization. When
8 they're performing well, I have a hard time seeing that
9 necessarily as a bad thing, and so I'd just point that out
10 to you.

11 There are other organizations that could compete
12 for these contracts if they can qualify to be a QIO. There
13 are requirements in place to be a QIO that were put in place
14 to provide a connection with the community. A lot of that
15 was physician driven at first, but there have been changes
16 in the contracts and in the way the regulations require the
17 boards to be set up for these organizations that have spread
18 out the representation across provider types, including as
19 well having consumers on the boards of directors of these
20 organizations. So they're much more diverse in the
21 representation and the participation of the community in the
22 organization by requirement. And so organizations that can

1 meet those requirements can compete, and that's certainly
2 welcome.

3 I would say that looking at focusing on low
4 performers only is not necessarily an inexpensive
5 proposition. The QIOs are doing that now in the 9th Scope
6 of Work. With the amount of funding they have available,
7 the numbers they can work with are very small. So what you
8 lose when you do this is efficiencies that you can gain from
9 having an organization, one organization that is spreading
10 out costs across the providers that they're working with.
11 So, you know, you have to be careful with how you're going
12 to approach this. If you're going to have lots of different
13 providers, you're not going to have the ability to spread
14 out that overhead.

15 I agree with Mary Naylor about the performance
16 measures not necessarily always correlating with financial
17 status. Maybe I'm misreading whether you said that, but I
18 think there's certainly evidence that that's not always a
19 strong correlation, so I think we have to be careful there.

20 I just would say we need to walk cautiously into
21 this, and I would urge just continuing to think about some
22 of these recommendations and how they're ultimately going to

1 impact not only the organizations but the people they're
2 trying to serve, which is the beneficiaries.

3 MR. HACKBARTH: And I'd urge you to, if you
4 haven't already, be in contact with our staff and also take
5 advantage of the opportunity on the website to register your
6 comments.

7 MR. BRINGEWATT: My name is Rich Bringewatt, Chair
8 of the SNP Alliance and president of the National Health
9 Policy Group. I'll be very brief and follow up with staff
10 subsequent to this with some more detail. But I just want
11 to make a few comments, one in relation to the lack of data.

12 The SNP Alliance kind of shares a lot of the
13 frustrations and concerns that were expressed here today --
14 in fact, are fully supportive of the kind of recommendations
15 that were made. We are in our third year of a data
16 collection of all of our members that looks at specific data
17 in terms of member characteristics, utilization in terms of
18 hospital utilization, et cetera. We'll be happy to share
19 that information. It relates to about 650,000
20 beneficiaries, so it's about half of the SNP enrollment that
21 cuts across the SNP types. So I'd be happy to share some of
22 that.

1 We support kind of caution and concern about use
2 of some of the specific measures that are in existence as it
3 relates to HEDIS and star measures, particularly as it
4 relates to high-risk populations, have some recommendations
5 in terms of how those might be saved. We're particularly
6 interested in moving rapidly towards an outcome measurement
7 approach, looking specifically at five outcome measures --
8 hospital utilization, long-term nursing home stay, emergency
9 room visit, adverse drug events, and consumer satisfaction -
10 - as a place to begin in terms of looking at outcome
11 measurement.

12 Don't underestimate the importance of aligning
13 Medicare and Medicaid payment and policy and oversight
14 structures. Medicare and Medicaid use different definitions
15 for care management. States and CMS have different
16 expectations in terms of models of care. You kind of
17 scratch below the surface and in virtually every piece
18 there's something different. Moving forward with encounter
19 data collection on the Medicare side, there's no connection
20 of the Medicare encounter data with the Medicaid encounter
21 data, so that there's concerns there in relation to how we
22 deal with dual SNPs.

1 A few quick things as it relates to points of
2 clarification. Dual SNPs don't get paid more money than
3 other MA plans, and they also aren't exempt from marketing
4 regulations.

5 Secondly, there's a fairly significant number of
6 people under 65 particularly that are part of the SNP
7 Alliance plan. The survey has 40 percent of dual SNPs under
8 65, a way to begin to look at some of those. Institutional
9 SNPs and chronic SNPs, virtually all institutional SNPs are
10 focused on duals. Some C SNPs are also exclusively focused
11 on duals. So look more broadly.

12 Then finally--

13 MR. HACKBARTH: Okay.

14 MR. BRINGEWATT: One last quick -- dual SNPs
15 aren't all for-profits. We have Kaiser and Health Partners
16 and UCare and a number of other nonprofit organizations that
17 are actively engaged. So thank you.

18 MR. HACKBARTH: Okay, and please do take advantage
19 of talking to the staff and using the website. Sorry to
20 have to cut you off.

21 MR. BRINGEWATT: That's all right.

22 MR. HACKBARTH: Okay. Thank you all and see you

1 in April.

2 [Whereupon, at 11:51 a.m., the meeting was
3 adjourned.]

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