# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Thursday, September 6, 2007
11:41 a.m.

COMMISSIONERS PRESENT:

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NANCY M. KANE, D.B.A.
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WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, PH.D.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Welcome to the members of the public in the audience. As you well know, we're starting a new MedPAC cycle and have lots of interesting issues.

Before we get to the published agenda that I hope you have, we have one carryover item from our executive session which is a real brief update for the commissioners on the inpatient prospective payment system reg, and in particular the issue of severity adjustment, which has been an issue of long-standing interest to the Commission. And so Jack and Julian are just going to do a brief update on what CMS has proposed there and the status of that.

MR. PETTENGILL: We're just going to give you the highlights here. You can find more detail in the summary that was included in your Tab A.

I'm going to begin with the case-mix refinements that CMS adopted and then Jack is going to talk about the other major provisions.

CMS is making major case-mix refinements for 2008. They're also making some changes in related policies

in an attempt to deal with the expected impact of these refinements.

The most important change is that a new patient classification system called Medicare Severity DRGs replaces the current DRGs. The new system has 745 groups, as compared with 538 in the current DRGs.

The so-called MS-DRGs make use of the findings from a new study in which CMS determined the status of each secondary diagnosis in one of three levels as a major CC, or comorbidity and complication, a CC or a no CC. The 745 MS-DRGs result from splitting 335 base DRGs as many as three different ways, depending on the presence of an MCC, a CC, or a no CC.

Among the alternative severity systems that were evaluated by the RAND Corporation, this MS-DRG system is not the most powerful. On the other hand, it is relatively easy to implement and to maintain, and it does make substantial improvements in severity measurement and in payment accuracy.

CMS is adopting this new system with a two-year transition that is concurrent with the remaining two years transition from charge-based to cost-based weights.

The major related change is the adoption of prospective adjustment for changes in case-mix reporting. In making changes to the classification system and the weights, CMS is required by law to make an adjustment to the base payment amounts, to prevent the changes from affecting total payments to hospitals. The law specifically permits CMS to make adjustments to offset the anticipated effects of changes that hospitals make in documentation and coding in response to revisions in case-mix measurement methods. CMS is making an adjustment of minus 4.8 percent spread out over three years beginning with a minus 1.2 percent adjustment this year and followed by minus 1.8 adjustments each year in 2009 and 2010.

These offsets may be revisited and changed as appropriate, as data on the real impact becomes available -- that is actual experience -- beginning with the proposed rule for 2010.

Now Jack will give you the rest of the story.

MR. ASHBY: The second biggest change in this rule is in the area of hospital acquired complications. CMS identified eight conditions for which it will no longer pay the extra amount caused by the complication placing the

case into a higher weighted DRG. Three of these are so-called never events, like object left in surgery. Some of you asked us about a Robert Pear [phonetic] article that seemed to imply that Medicare would not pay at all for these never event cases. But that was just a case of ambiguous wording. Medicare, in fact, will continue to pay the DRG rate that would have applied in the absence of the never event.

Many were surprised that CMS did not include MRSA infections in this program, given the attention that these drug-resistant infections have received, but MRSA is not a CC or a major CC so its presence alone would not result in additional payment and that pretty much disqualified it from the criteria of this program. But in addition to that, there is some question as to whether this infection can always be detected at admission.

Although this policy may cause hospitals to examine their treatment practices to minimize the chances of being penalized, in reality we expect the penalties to be applied in relatively few cases. Under the new MS-DRG system higher payment is triggered by any one CC or major CC. So when one of the target conditions is acquired after

admission the hospital may still receive the extra payment increment if some other CC is present.

And then finally, to support this provision, CMS is requiring hospitals to report on their claims whether every secondary diagnosis was present at admission.

Other key provisions, briefly, first in the area of capital. CMS made two changes in capital payments that will reduce payments over the course of three years. In the area of quality data, hospitals now need to report on 27 quality measures to avoid the 2 percent payment penalty specified in DRA. CMS added one additional measure for 2009, that's the 30-day mortality rate for pneumonia. And they have signaled that they intend to add three more measures through the outpatient final rule that will come out in November, as long as NQF endorsement is received by that time.

CMS estimates that the net increase in payments in 2008 will be 3.5 percent for operating payments. That's with an update of 3.3 percent. And then the net increase in operating and capital payments combined will be 3.3 percent. We have to note that these estimates assume that the actual payment increase coming from coding

improvement will exactly match the 1.2 percent payment offset that Julian described earlier. So the actual increase that hospitals receive could either be higher or lower than this estimate.

That's it unless anybody has any questions.

MR. HACKBARTH: Any questions?

DR. WOLTER: On the behavioral offset, I was wondering if an organization codes accurately, will they get their full market basket update? Or will they be down by 1.2 percent? In other words, what's the intellectual property theory behind this behavioral offset? Or do you have to upcode to get yourself to the market basket update?

DR. REISCHAUER: Punish those who have done good over time.

DR. WOLTER: The question is does an ethical organization take a hit in this deal?

MR. PETTENGILL: That comes down to the quality and completeness of the coding they do now. If they're coding fully completely and fully accurately, the adjustment to the standardized amounts will apply to them like it does to everyone else and they will be down 1.2 percent. If they're not fully coding accurately and

completely and they start to do that there will be some offset, some trade-off between the two, depending on how much of a change that makes.

MR. HACKBARTH: I also think we need to be careful not to imply that all changes in coding are nefarious and a conscious effort to wring money out of the system. When there's a reason to code something with more detail, people spend more time on it, spend more of their resources on it, and do a better job. So there can be some increase in the reported case-mix for perfectly legitimate reasons.

But it does increase payment for patients that are no different. The reasoning behind the offset is that this is supposed to be, by definition, a budget neutral change and so we don't want to just pay more for the same patients just because of a change in coding practices. It's not about punishing people. It's just keeping the system -- maintaining the integrity of the system.

DR. WOLTER: I'm sure that's the theory. I guess when you boil it down to the level of the individual institution though, it may well be that ethical organizations that do this well are going to take a pretty

big hit because of the 1.2 percent adjustment. I'm conflicted on this. We have a hospital in our organization. But I will say that I was at a presentation that a consultant did to us last week. And they did a lot of chart audits of our current coding practices. They are predicting a $2 million decrease related to this policy in reimbursement to the organization. And of course, for a substantial fee, will help us with our coding practices going forward.

[Laughter.]

DR. WOLTER: Just so people are aware of what this all means at the ground level and kind of all the consternation that's being created.

MR. ASHBY: But I think it's worth remembering that regardless of whether the hospital is already coding appropriately because they have gained skills in the past or whether they are beginning to code appropriately this year to catch up, either way they will receive the benefit of the additional payments for the high severity cases. So all hospitals will be paid appropriately for those cases.

Hospitals that now begin to get paid less, it's because they don't have severe patients and, in some respect, they have been gaining from that in the past.

DR. MILLER: That was something in the first exchange and the response to this. I would have thought that the answer -- and I think you just said it but I just want to make sure I've got this straight.

If the hospital is doing as complete coding as possible, then they will immediately move into more severe categories, whether the patient has changed from one year to the next, and will, in fact, enjoy higher payments.

DR. KANE: Why wouldn't they just as likely move into less severe because of more complete coding?

DR. MILLER: I'm talking about a hospital that -- in the example of dealing with this more severe patient population, those hospitals will immediately go up. It was sort of cast as ethically. I think that's sort of what I'm taking on here is that a hospital can be just doing its complete coding. And if they're dealing with more severe patients right now, they are being underpaid and their payments will increase. Then hospitals who are dealing with less severe patients, that adjustment will occur.

Remember where we came from in all of this was correcting that systematic issue that was prevalent through the payment system now. I just want to make sure that that point is also not lost in this.

MR. HACKBARTH: Let me pick up on this. And unfortunately, we're really not scheduled to have an extensive discussion so we're going to have to bring this to a close.

But let me close with just restating what I think were the basic reasons for our endorsing the idea of severity adjustment. One was a basic issue of equity. There are institutions that are treating sicker patients than others in a way that isn't fully appropriately captured by the current system. So it's a matter of equity.

Second is to the extent that there is mispricing, persistent mispricing, it drives investment. You have institutions investing in certain types of services that are high profit and underinvesting in other services that are equally important for patients but are low profit. And we get a skewed pattern of investment.

Finally, there is the fear that if you have extraordinary profit opportunities, that it can begin to skew the organization of care and even affect clinical decisionmaking about what the appropriate services are and the appropriate place to deliver those services. So this problem of inaccurate pricing has very important consequences for the shape of the delivery system and it is, in my view, very, very important that it be addressed.

Last comment.

DR. WOLTER: Yes, and I certainly am a big supporter of that, Glenn.

I just am struggling philosophically with whether or not the behavioral offset is needed for budget neutrality if organizations code to this new severity appropriately, because some would go up and some would go down.

Real quickly, I wanted to mention as we look at this list of never events I know there are some in the hospital world who feel some of them are harder to be in control of than others. Falls, for example. I just wanted to get that on the record. I think there's going to be some struggle with this as it goes forward.

For example, MRSA, which isn't on the list, we've been doing surveillance studies as part of a project to reduce MRSA in our institution. And about 5 or 6 percent of our patient, as they're admitted, are colonized with MRSA. Most institutions don't do any surveillance studies, they're expensive.

And so there's lots of issues here that I think need attention as this whole movement towards so-called never events goes forward.

Thank you, Glenn.

MR. HACKBARTH: Thanks, Jack and Julian.

DR. CROSSON: Could we get copies of the presentation?

MR. HACKBARTH: Sure.

DR. MILLER: You can have that but also you have a summary under Tab A.

MR. HACKBARTH: Now moving to our scheduled agenda, the first item on the list is a presentation by Evan on our context chapter.

MR. CHRISTMAN: Good afternoon.

Next we will review the broad economic and financing challenges facing the program. These issues are

important because the MMA requires the Commission to consider the budgetary context of its recommendations. This presentation provides an overview of the program's current budgetary situation and helps to set the stage for this fall's discussion of the update recommendations.

In prior years this chapter has included a discussion of policy alternatives. We anticipate adding that discussion of policy issues later in the fall.

In April the Trustees released an updated appraisal of the Trust Fund's health. And they found that the year of exhaustion for the Hospital Insurance Trust Fund had moved back one year to 2019. In that year the Trust Fund will have exhausted all of its financial reserves it has accumulated and be left only with the taxes it collects every year from workers and beneficiaries as a source of income. Consequently it will only have enough income to pay about 80 percent of the benefits due. Without any changes, this deficit is expected to increase in future years as the cost growth for Part A benefits is expected to exceed the projected future growth in payroll taxes.

The Supplementary Medical Insurance Trust Fund which funds Parts B and D does not have an exhaustion date because it is funded through a mixture of revenues from the general fund and beneficiary premiums. However, even assuming no changes to physician payments the fund is expected to require a growing share of federal revenues. In 2006 the portion of the Supplementary Medical Insurance Trust Fund funded by taxes totaled 10 percent of corporate and personal income taxes. This amount is expected to grow by 30 percent by 2017.

If the SGR were repealed and replaced with an automatic MEI update, the share of the general fund required in 2017 would grow by 50 percent compared to today's level.

In addition, beneficiaries will also face a strain on their finances. Today the cost sharing for Part B and D consumes about 30 percent of the average Social Security benefit. As health costs continue to exceed the rate of growth in Social Security benefits, this amount is expected to reach 36 percent of the average Social Security benefit.

And finally, in 2007 the Trustees issued a Medicare funding warning as required by the Medicare Modernization Act. The warning was triggered because in this year's Trustees' report, for the second year in a row, the trustees reported that the share of Medicare funded by the general fund will exceed 45 percent in the next few years.

Under the MMA, the president is required to submit legislation in 2009 to bring expenditures back under the target and the MMA authorizes expedited legislative procedures for Congress to respond.

Like other health care programs, Medicare growth has historically exceeded GDP growth. In 1970 Medicare was three-quarters of one percent of GDP, and by it had almost quadrupled to 2.7 percent. By 2040 it is expected to triple, to 8 percent of GDP.

The factors underlying the past and future growth should be familiar to you. The factors that increase spending for Medicare also increase it for the nation. First, the nation's income has been rising. Many analysts suggest that it is natural for people to demand more health care as incomes improve, as the marginal value of

additional life span or function may be worth more than other goods.

New technologies also have been cited as increasing spending. New technologies can yield improvements in health but they can also yield new costs and inefficiencies. As the Commission has noted, there is not an adequate evidence base to ensure the appropriate use of new technologies and consequently new therapies may be used even if they're not the most efficient or effective.

Inaccurate prices that overvalue certain therapies or procedures can also distort the incentives for delivery of care. When inaccurate prices allow providers to reap windfalls, it can provide an incentive for higher utilization and lead to growth in spending. Mispricing can also lead to distortions in the investment and new technologies and the organization of the delivery system.

Insurance has provided beneficiaries with financial protection, but it also shields them from the full cost of the care they consume. Consequently some beneficiaries may consume more care than they would have otherwise. Estimates of the insurance affect on the

increase in per capita growth vary but range from 10 to 50 percent.

Also affecting health spending is our underlying health status of the nation and changes in provider's pattern of care. A recent study by Ken Thorpe estimates that most of the growth in health care spending can be attributed to beneficiaries with five or more chronic conditions. The proportions of beneficiaries with that many conditions grew from 31 percent in 1987 to about 50 percent in 2002. At the same time, people who have five or more conditions now have a higher self-reported health status. In 2002 about 60 percent said they were in excellent or good health compared with about 33 percent in 1987.

The authors conclude from this that providers are treating healthier patients, that treatment is improving health outcomes, or that both is occurring.

The authors also believe that obesity plays a part in this because many obese individuals have multiple comorbidities and the prevalence of obesity has grown substantially.

Again because of these factors, health care costs for both the private and public sector are expected to exceed GDP. Here you can see the impact of that excess growth, with health care spending rising from 9 percent in 1980 to about 16 percent in 2005 and expected to exceed 18 percent by 2016.

The upper light colored area is private spending on health care. And the bottom three areas split public spending into Medicaid, Medicare and all other public spending. As you can see, public spending has risen to be about half of all health care spending and it is expected to grow faster than private spending over the coming years. About three-quarters of the public spending is Medicare and Medicaid.

While the growth of health care as a share of GDP may raise concerns, from an allocation prospective it is not clear there is a correct level of health care spending. Some analysts have suggested that a nation as prosperous as the U.S. should spend up to 30 percent of its GDP on health care. Others though might argue that much of the growth is due to inefficiency in the delivery of care and inappropriate incentives that may raise volume. To the

extent that these factors account for growth, the increasing share of GDP committed to health care may not reflect society's preferences or an efficient allocation.

The U.S. spends more per capita on health care than any other country in the world. This comparison shows how much the U.S. spent in 2005, about $6,400.

To the right of the blue bar are the next four highest spending OECD countries which, while higher than the OECD average, are still significantly lower than the U.S.

The final bar on the right is the OECD average of all 30 countries, about $2,800, less than half of the U.S. level of spending.

In addition to spending, many analysts have raised concerns about quality in the U.S. system. International comparisons suggest that even though we are the highest spending nation the system does not always deliver the best care. While the U.S. system has many advantages, other lower spending systems attain better outcomes. For example, a comparison by the Commonwealth Fund found that the quality in the United States lagged those of other leading OECD nations in life span,

preventable mortality, and the rate of medical errors. And even within the U.S. there is clear variation in the quality of care. For example, the rate of correct timing in the administration of antibiotics before surgery varies from 50 to 90 percent. The rates of nursing home patients with pressure sores ranges from 7.6 to 19 percent. And rehospitalizations for Medicare patients varies from 13 to 24 percent. These variations suggest that where you live can affect the quality of care you receive with some receiving excellent care and others mediocre.

If policymakers cannot find ways to address these issues soon there may be consequences for future generations. The system we have today evolved over many years and addressing these issues will take time. Consequently, if efforts are not taken relatively soon future generations may not have all the tools they need to tackle these challenges.

In the chapter of this presentation we have included an overview of the financing issues. We please let us know in your discussion if there are additional factors you would wish to add.

This completes my presentation.

MR. HACKBARTH: Evan, can I ask a question about something you said right in the middle of your presentation? You said that public spending is projected to increase more rapidly than private spending. Does that control for the growth in public beneficiaries, in particular Medicare beneficiaries? Is that on a per covered person basis?

MR. CHRISTMAN: I believe that's just looking at it in aggregate.

MR. HACKBARTH: Because looking back, lots of discussion about comparing the growth rates. Basically I think they've been pretty similar over the last 25 years on a per person basis.

MR. BERTKO: Evan, nice report there. I guess I have two comments only for you to consider in the next draft of this.

The first one addresses one of the comments you record on page six which says that the HI Fund payroll taxes have been exceeded by expenditures for the first time in 2004 which I follow along something like that. I am perhaps suggesting that the urgency of all of this be increased a little to put a dollar amount in there for

maybe the 2008 budget year according to the projections so that we don't meet until 2019 when the fund actually goes broke but see that the size of the demand on the treasury under the consolidated budget is going to be a substantial number of billions of dollars. That's one comment.

The second one is just to go back to I think what we talked about in July about looking at supplemental and Medigap insurance. There's that one older study out there. My recollection was that staff is again re-examining that to update that? Is it the case?

MS. THOMAS: Rachel is going to talk about that this afternoon.

MR. BERTKO: I guess I would suggest in this context perhaps putting in a paragraph that describes the timing of that or the new results if they are available. Because the old numbers have such a large impact that it's worth at least thinking about in this context chapter.

DR. CROSSON: If we could look at slide five for a second, thanks.

When I read the chapter, and now looking at this slide, I wonder whether there's not another topic to add there. It has to do with the impact of payment

methodologies, spending increases over time. I think that that is probably missing.

Certainly, I think as we talked about the issue of trying to fix the SGR or the fact that that payment methodology in Medicare does not contain a mechanism to deal with volume would be an example of this. I think the issue we were just talking about earlier in terms of changing payment methodologies to hospitals in order to take -- to fix problems that have evolved in the DRG system over time and have led to perturbations, as you said, in delivery system is another example. I think the notion that fee-for-service payment for physician services combined with technology also has a cost escalating approach are just some examples of that.

But I think although you can point to examples in OECD countries where fee-for-service payment is the rule, there still are other financial mechanisms such as global budgets which tend to have a reverse impact on that. So I just think if we're talking about why has and why does spending continue to increase in this country, the issue of the impact of various payment methodologies should be added. DR. SCANLON: My comments are actually on the

same page. I think that there are some more aspects to the study, to the set of factors that influence things. And there's interactions among them to make these things happen. With respect to insurance, I think we should be adding potentially a factor, which is information. Because yes, insurance does reduce the financial price that patients pay. But if patients knew the value and the risk of procedures they might have a different sort of perspective on them. As we talk about the issue of providers that induce demand in various places in our work, this is the area where information may play a role. And since we've recommended that we --

MR. HACKBARTH: I agree, and there's evidence to document the patients, if they have better information, make somewhat different decisions.

DR. SCANLON: So I think that would be --

DR. REISCHAUER: This is about why spending is increasing. And I thought you were going to say something very different, which is when you turn on your television set and they say come on down and have a an MRI. I mean, it's been a week since you've had one.

[Laughter.]

DR. SCANLON: There is that aspect of it, which is sort of not only is there an issue of bad information but there's no counter-information to make an informed decision. The information side of this, so patients are armed with understanding the value of what the services are.

The other is the issue with respect to prices. I think this is a phenomenon that we've been seeing more in the last eight or nine years, since we've had the backlash against managed care. And that is the issue of market concentration and the fact that on the provider side, in particular, there has been a move towards consolidation. So that we have hospital systems instead of individual hospitals negotiating with insurance companies and we have groups of doctors negotiating instead of -- and larger groups of doctors that are being formed not necessarily for good clinical reasons but to be better bargaining units. As this continues, it creates an issue.

Now I don't want to leave out the other side of this equation, which is we've also had consolidation on the insurer side. We don't necessarily want an intervention that says wait a minute, the providers need to be

restrained so that they are not as effective bargainers when we don't have something on the other side of the market in terms of the restraints that are on insurers.

But I think these are factors that have been influencing certainly a number of markets already and the question is how far this is going to spread.

DR. MILSTEIN: My input would be to see if there isn't a way in this year's chapter to, in a more salient way, communicate what I consider to be a very central point, which is that the problems that we're trying to solve are related to affordability and quality. The factors that are driving those two problems are dynamic self-propelled factors, essentially that it just keeps coming at you, the biomedical technology being a terrific illustration.

Accordingly, any solution that's not equally dynamic in terms of continuous evolution to offset those opposing forces won't work. We're never going to come up with -- if we keep a static mindset, we'll never be able to keep up with this steady rate of drivers of both unaffordability of cost and quality dangers associated with increased complexity of clinical care.

So if there's some way of conveying the central point that whatever a solution is it needs to be one that is dynamic. I believe a vision for this, we've talked about this before, is something along the lines of a solution that induces a rate of annual clinical efficiency gain or clinical value gain, movement of both the quality and affordability that we know at least on the affordability side has to be at least equal to two to three real points a year to possibly solve the sustainability problem.

And then in terms of what we might say more specific about this, you could frame this in terms of adding to the list on page five of what we don't do. Or you could frame it as a vision of what we ought to do. It could go in either place.

I would say it's figuring out how we address the lack of coordination of Medicare strategy with private sector strategy. You can't drive what we're after if you're only controlling 20 to 25 percent of the total amount of money flowing in.

We reference that briefly in prior reports but I think we need to hit it harder because yes, Medicare is the

single biggest lever but I don't think you're going to fundamentally -- the idea of fundamentally changing methods of delivering care with only 20 percent, a 20 to 25 percent lever is, for me, not plausible.

The second point is I guess the Hellastat point of, in essence, we have to figure out how we induce a rate of clinical efficiency innovation that delivers that two to three points. And I think make the point that it's not impossible. Many other consuming facing industries over last 10 or 15 years, according to Hellastat, have begun to generate four to six point annual improvements in either affordability, quality -- pick one or the other or pick a blend is probably what I would pick. That's not an impossible vision, understanding that it is -- clinical care is more complicated than widget production.

MR. EBELER: Sticking with this slide, it's hard to tease apart why is spending high and why is spending increased. But it strikes me that elsewhere in your chapter and in your presentation you talk about some of the delivery and efficiencies and some of the Fisher data on supply induced demand for supply sensitive services. It strikes me some of that belongs here, especially when you

get into international comparisons. You also need to look at sort of the comparative efficiency, administrative efficiency of our insurance system versus other nations. I don't know how to fit that in here.

I would echo John's point of pointing to some of the short-term cost impacts. We've rolled out share of GDP to 2080 and those are really scary numbers. It's not working in terms of getting people engaged and pointing out some of the much shorter term, this is hurting your part B premium, it's really impacting -- it might be worth trying to get some of those messages out there as well.

MS. BEHROOZI: Thanks. This is a challenging job, I'm sure Evan, to bring together all of this information and all of these arguments and positions into a cohesive document. I think you've done a great job starting out. There's a lot more to do, I guess.

One of the suggestions I would make is when you're talking about the why for the reasons for high levels of spending in the U.S. on health care, it seems that there is a focus on one specific in terms of doctor compensation. But there isn't a similar focus on other areas like pharmaceutical costs in this country as compared

to other countries or even reflecting back to some of the other point that you make earlier about the fragmentation of the system and things like that. So it just seems like maybe a little more than an expansion of the why might be helpful.

Also, in terms of the organization of the paper as compared to the presentation, you made a very clear link or you articulated very clearly that there isn't a link between higher spending in the U.S. and higher quality as compared to other similar countries.

In the paper I think that it's a little more attenuated. It comes much later where you talk about the fact that we're not seeing enhanced quality for the enhanced spending. And then I think some of the other comparisons that you make to other countries before talking about the quality differential aren't maybe as effective.

I have a question and maybe there are people here who know the answer to this or maybe we don't know the answer yet. The last part of the paper, where you're talking about consequences of the growth in health spending, you talk about how -- and one of the things that's happening is that employers are shifting more costs

on to their employees. And then later in the section you talk about new insurance products like HSAs.

My question is whether an HSA-type arrangement is really just another kind of cost shifting by the employer? Or is there really something new about it that impacts, that has the potential to impact cost growth in health care spending?

Because when people use their HSA money, they're out there purchasing as individuals, as opposed to whether its an insurance company or in our case a trust fund that puts everybody's purchasing power together, we are able to get rates that individuals aren't able to get. Now maybe they can choose between two rates that they're offered by competing providers, but it seems to me they still don't have the economic clout, the purchasing power to really drive that rate down unless there are a lot of people out there doing that on their own, I guess.

So I don't know whether there's any evidence yet or there's been any modeling that really shows that HSAs will have an impact on cost growth or, like I said, it's just another way to the shift more cost to the worker.

DR. REISCHAUER: Mitra, that's not always true, because your catastrophic plan usually allows you to purchase from their network at the network price because that's what they're counting towards your catastrophic limit. And so if it wasn't, you'd really be up the creek.

MS. BEHROOZI: I just once saw an article that talked about a family that had $3,000 in their HSA and couldn't buy what they needed with it on the open market. So that was one story.

DR. REISCHAUER: It's not that there aren't plans like that, but the ones that employers are providing, by and large, are not...

DR. STUART: I'd like to look at your fifth point there in terms of chronic conditions and obesity. There's a tendency to throw all of this together and to consider obesity a chronic condition. You don't say so, but it is not.

But more importantly, there is this assumption that the greater the weight gain, the greater not only the likelihood of chronic conditions but the higher the cost. In fact, there's no evidence that supports that. The cheapest class of Medicare beneficiaries are those who are

formally considered overweight. They are significantly more expensive than those that are considered normal weight. And people who are considered class 1 obese, which is a body mass index of 30 to 35, are actually just as expensive as people who are normal weight.

It's only when you get into the morbid obesity do you find that you find a real increase in costs associated with him. That's a very small percentage of the population. Also, it's a very interesting percentage of the population. Almost half of all Medicare beneficiaries who are morbidly obese are under SSDI, they're under 65. And if you add people who are formally SSDI, then it's over 60 percent of all the morbid obese Medicare beneficiaries have this connection with disability. So I think there's clearly something here but it needs to be a little more nuanced I think.

DR. KANE: I just thought if we're going to be talking about reasons that spending is either at the high level it is or increasing, I don't know how you tease it apart either, and most of what we talk about is changes to the industry structure, at least in terms of a lot of what we're talking about in terms of reform, we should have

something in there about industry structure as a cause for and how we are thinking through industry structure. For instance, fragmented delivery systems, lack of coordination, lack of information, lack of transparency, missing information systems across handoffs of care.

So I just thought there should be a section in here about the very delivery system problems that we think are contributing to this rise in costs so that we can then go from there to our solutions.

The other topic that we kind of hint at and prices is kind of going at it is the a structure of the market. I think we believe in this multiple payer competitive market with a large regulated payer in the middle of it. But we've gone with that model and we need to talk about what that means in terms of its contribution to spending. A lot of other countries have one payer. They use competition in a very managed way and a very narrow way. I think we need to address directly the fact that the structure of our markets may well contribute to the fact that we are the highest cost country in the world and identify the variables behind that such as the market power of insurers and the market power of providers in some

markets and the fact that Medicare is only one of many payers and the fact that the consumer really doesn't know what's going on half the time.

I just think we have these two big topics that are the ones we really plan to address and we're not going to do much about income, I hope, at least not as a commissioner I don't want to.

I think we need to get out the things that we think we're going to be talking more about when we come up with solutions.

MR. HACKBARTH: Thank you, Evan.

We are going to adjourn for lunch and reconvene at 1:30.

Oh, public comment, right.

DR. MILLER: So you're assuming they will be short.

MR. HACKBARTH: Yes, I'm assuming they will be short.

Are there any public comments?

See, I told you so.

[Laughter.]

MR. HACKBARTH: We will reconvene at 1:30.

[Whereupon, at 12:26 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION [1:29 p.m.]

MR. HACKBARTH: Our first session this afternoon is on hospital and physician relationships.

MS. MUTTI: This presentation explores two types of relationships, collaborative ones and competitive ones, between hospitals and physicians. And this summary is intended to do at least three things. It's intended to help commissioners consider the impact these relationships might have on volume and quality; also how creatively and dynamically providers respond to incentives, particularly in a fee-for-service environment; and thirdly and maybe most importantly, how the industry might respond to possible policy changes that the Commission might be considering. Here we're thinking of things like A/B bundling or other payment incentives to encourage greater coordination and collaboration to improve value in health care.

The sources that we've used for this presentation include site visits that we conducted, conference proceedings, published literature and our own analyses. I would say certainly on the collaborative side of relationships, we're a little bit newer to some of these

strategies, relationships. We're coming up the learning curve. We'll certainly try and answer questions but there might be some that we'll just need to get back to you on.

The strategies we discuss here and that are on this slide are a mix of things. They vary in their effect on volume, quality, costs and Medicare spending. And some are more recent trends in the market as best we can tell and some have been around for a long time but probably have evolved as the regulatory environment has changed and other aspects of the market have changed.

We will briefly discuss each, with the exception of participatory bonds, which is in the paper and we're happy to take that on question.

We also recognize that this is not an exhaustive list of the types of collaborative relationships that are out there and we'd certainly be happy to take any suggestions for ones that we should look into.

As we go through the collaborative relationships, bear in mind that the trends will vary geographically. You'll see some of these in some markets and not in other markets.

Stakeholder motivations also very. Hospitals pursuing some of these strategies may be acting defensively, responding to perceived threats such as physicians opening their own health care facilities, or maybe a neighboring hospital that's decided to aggressively expand a service line, or even the threat of some physicians choosing to stay out of the hospital and really concentrate their practice in their own office.

Hospitals may also be taking an offensive posture, using these strategies to really get a competitive advantage in the market and grow a service line.

The P4P quality movement likely also brings both hospitals and physicians, makes them increasingly interested in collaborating to the extent that they need each other to improve their performance on quality metrics.

Physicians may also be motivated to partner with hospitals to increase their efficiency which would in turn increase their productivity and maybe also increase their revenue by sharing in hospital profits and maybe profits having to do with ancillary services. And certainly in the case of hospital employment perhaps it's motivated by improving lifestyle or professional satisfaction.

We start with hospital recruitment of physicians. Hospitals have a strong interest in ensuring that there is an adequate number of physicians present in their communities and that they're sending their patients to their hospital. Accordingly most hospitals -- 86 percent according to one survey -- are actively recruiting physicians to be part of either an existing group practice in their community, a solo practice in their community, or to be employed by the hospital. Of those, about 80 percent are recruiting specialists.

Busy physicians who perform services in the hospital that are well reimbursed are valuable to hospitals. For example, the average estimated hospital inpatient and outpatient revenue associated with an invasive cardiologist is about $2.7 million. And that's according to a survey of hospital CFOs.

The hospitals' cost of recruiting a physician can be considerable. Here I'll just focus on recruitment of physicians practicing in the community, not employed by the hospital. The largest portion of hospitals' costs in recruiting these physicians can be an income guarantee. The hospital pays a salary to the physician to the extent

that there is a revenue shortfall. So it ensures that that physician meets his or her targeted salary and also pays for overhead expenses associated with starting up their practice.

It's technically a loan but if the physician stays in the community, say something like three years, that loan is forgiven by the hospital. The guarantee can be around $300,000, $500,000 for some specialists. It's usually extended over one or two years.

Other usual expenses include paying for a physician's benefits, and this can also include loan forgiveness, their educational loan forgiveness, as well as just bonus payments, a starting amount. Both of those types of payments seem to be on the rise.

Given the value of the physicians to hospital revenue, hospitals are increasingly investing in liaisons or sales teams who visit community physicians with the primary goal of maintaining or increasing their use of hospital services.

Consultants report a spectrum of activities that these liaisons may get involved with. It may range from simply checking in, presenting a friendly face for the

hospital, apprising them of any new services that they have available, to something more aggressive or a little bit more involved, maybe resolving any kind of issues in getting preferred OR time, being sure that diagnostic test results are coming back in a timely way.

To the other side of the spectrum, it can be about referring referrals among physicians and helping them with a marketing plan.

Hospitals are increasingly paying community physicians for clinically related services. Some are paying physicians to serve as medical directors for a particular service line. This can be on a full or a part-time basis. Some are paying physicians for attending committee meetings. Some are also paying them for caring for uninsured patients in their hospitals. They might be paying them Medicare rates or even higher.

Hospitals are also increasingly paying physicians for emergency department coverage. The majority of hospitals -- 73 percent according to one 2005 survey -- said that they find maintaining adequate call coverage a problem. That same study found that 36 percent of hospitals are paying physicians for emergency room coverage

and that's up from 8 percent in just one year in 2004. Typically, hospitals are paying something about $1,000 per day for this coverage when they do pay.

Comanagement arrangements are another strategy used by some hospitals to compensate physicians. Under these arrangements a hospital and physician or physicians form a corporate entity and that entity, funded by the hospital, pays the community physician a salary for specific clinical tasks. This can be such things as developing clinical pathways, evaluating medical technology, assessing a drug formulary, recruiting physicians. It's usually related to a specific service line like orthopedics or cardiology.

The physician is also paid a bonus if certain objectives are met. The objectives can be oriented to such things like patient safety improvement, patient satisfaction, as well as efficiency, standardization and cost savings. According to at least one industry consultant, it could also include things like growing market share and meeting geographic growth targets. However anti-kickback laws would preclude the bonuses being offered based on increasing referrals.

If the physicians do respond to these measures on which the bonus is based, like shorter turnover time in the OR or prompt starts to surgeries, the physicians and the hospitals can treat their patients more efficiently and create greater capacity, which may in turn result in greater volume.

Another trend is hiring physicians as part or full-time employees. For example, according to a survey from a large physician recruiting firm, 23 percent of their physician search assignments in 2005-2006 were for hospital settings, compared to 13 percent in 2002.

The effect employment has on volume of care seems to vary. For example, at a conference on physician and hospital physician relationships, the CEO of one health integrated delivery system that does employ its physicians noted that their culture is oriented to servicing physician practices, making it easier for physicians to increase their volume. They consider this a win-win strategy, doing more increases the physicians' income because they are paid on production and it increases the revenue to the system.

Of course, other compensation models are possible. Some pay physicians on a salary basis only. The

concern with this model is that physicians tend to be a little less productive than self-employed physicians are and to pay less attention to costs of operating their practice. On one of our site visits we visited a system that had been using a strictly salary model and they, too, found that they needed to introduce some productivity incentives to improve their financial situation.

Another factor influencing volume may be the culture of the organization. Again, in our site visits we found some evidence of that.

Increasingly hospitals are hiring hospitalists. This seems to be motivated by a number of factors. Hospitals may find that they need them to care for patients as more primary care physicians and some specialists opt to focus on their office-based practice. Hospitals may also choose to hire hospitalists in the hope of reducing costs, improving throughput, especially in markets where there is capacity constraints, and improving quality.

The evidence on these savings and quality improvement is a little mixed. With respect to costs, some have found that cost per day increases but length of stay decreases. Others have found that hospitalist may order

more consults, driving up costs both for the hospital and Medicare. Yet overall it seems that most believe hospitalists are part of a cost containment strategy.

With respect to quality, I think the biggest concern in the literature is that their involvement will result in the discontinuity of care, it increases the number of hand-offs that occur in patient care.

Good communication between providers can avoid those kinds of pitfalls but often they may not be achieved. As we've talked about in the course of talking about readmissions, they're not always rewarded.

On the other hand, hospitalists may be more likely to adopt practice guidelines, adopt IT innovations. They are sort of a captive audience for that hospital and can be a good communicator to other physicians in bringing about the intended culture focus on quality.

The potential cost-effectiveness of hospitals may, in part, depend on how the hospitalist is paid. A hospitalist who is paid strictly on how many services is provided is more likely to bill for more visits and maybe more likely to call in consults to improve their productivity. On the other hand, if the hospitalist is

paid with a salary, with incentives to improve quality and reduce length of stay, the hospitalist is more likely to be cost-effective.

MR. WINTER: Gainsharing or shared accountability relationships are another type of relationship between hospitals and physicians. In these arrangements, hospitals and physicians agree to share savings from collaborations that reduce costs and improve quality. Such efforts could include reducing the cost of supplies and devices, scheduling operating rooms more efficiently, complying with critical protocols, or using fewer ancillary services. These arrangements have the potential to encourage cooperation among providers in improving efficiency by aligning their financial incentives.

Efforts to promote gainsharing in the 1990s were halted after the Office of Inspector General issued a special bulletin. This bulletin said that gainsharing is prohibited by a statutory provision that bars hospitals from offering financial incentives to physicians to reduce or limit services to Medicare inpatients.

The OIG also said that such arrangements could violate the anti-kickback statute by inducing physicians to

refer patients to the hospital with which they have the agreement. Since this bulletin, the OIG has approved several narrowly tailored arrangements that have features to protect quality of care and do not reward physicians for making more referrals of the hospital. However, hospitals that wish to get OIG approval have to go through a lengthy advisory opinion process, which is probably a strong deterrent.

In 2005, the Commission recommended that the Congress provide the Secretary with the authority to allow and regulate gainsharing as long as there are safeguards to ensure that such arrangements do not reduce quality or create incentives to increase physician referrals.

In addition, CMS is currently developing two demonstrations to test whether gainsharing can improve efficiency and quality.

We visited a few hospitals that told us about virtual gainsharing arrangements. Rather than the hospital sharing savings with physicians through actual payments, the hospital reinvests a portion of the savings in infrastructure that the physicians request. For example, when physicians agree to help the hospital negotiate lower

rates with vendors for surgical implants or devices, the hospital agrees to use some of the savings to build new operating rooms or cardiac cath labs or to buy new surgical equipment. The hospital is able to reduce its costs, freeing up money to reinvest in profitable service lines such as orthopedic surgery, while the physicians get new equipment and operating rooms that can help them improve their productivity.

One issue to think about is that these arrangements create additional capacity and higher physician productivity, which may lead to a higher volume of procedures, and it's unclear whether the additional procedures improve patient outcomes.

When confronted with a threat of physicians investing in their own facilities, some hospitals have responded by forming joint ventures with physicians. Examples of joint ventures include imaging centers, ambulatory surgical centers or ASCs, cardiac cath labs, and specialty hospitals. From the hospital's perspective, a joint venture allows it to reinforce physician loyalty and retain some of the revenue it might otherwise lose to a physician-owned entity. From the physician's perspective,

a joint venture gives them access to the hospitals capital and management expertise, a larger pool of patients, and potentially higher reimbursement rates from private plans. However, both parties must be aware of the tax implications and the physician self-referral rules. If the joint venture involves a nonprofit hospital and a for-profit physician group, the partnership must further the hospital's charitable purpose for it to maintain its tax-exempt status. The Stark self-referral rules prohibit physicians from referring patients for certain services to entities with which they have a financial relationship. The list of prohibited services includes imaging, physical therapy, clinical lab tests, and prescription drugs, among other services. However, there are exceptions for ASC ownership and also for ownership of hospitals in which the physician invests in the entire hospital.

Because of the legal risks, and the belief that they can survive physician competition, some hospitals have decided against participating in joint ventures.

DR. STENSLAND: Now we'll turn to asking the question what's changed in recent years? And why have physicians often chosen competition over cooperation in the

last few years? In our 2005 report on specialty hospitals, we discussed how Medicare payment rates encouraged physicians to set up specialty hospitals that focused on certain types of surgery or low severity patients. By adopting MedPAC recommendations for cost-based weights and better severity adjustments, as we heard this morning, CMS went a long way toward removing these incentives. However, there are still other reasons why physicians may choose competition over cooperation.

First, the Stark Law's whole hospital exception allows physicians to refer patients to hospitals that they have an ownership interest in. They have been allowed to share in the hospital's profit from these patients. However, there are legal obstacles, including the Stark Laws, to compensating physicians who are not owners for their referrals or admissions.

Next, owning ASCs or specialty hospitals can give physicians more control over their work environment, more OR times, and fewer chances of having one of their elective surgeries being bumped from the OR for an emergency surgery. By owning their own operating rooms, physicians can complete more surgeries in less time.

And finally, in recent years there have been increasing financial incentives to focus on privately insured patients, as we can see on this next slide. As a way of background, note that physician-owed orthopedic and surgical hospitals receive a majority of their revenue from privately insured patients. And while cardiac hospitals receive most of their revenue from Medicare, a larger share of their profits are derived from serving privately insured patients. Therefore, payment rates for privately insured patients will have a significant effect on the expected financial gains of investing in physician-owned hospitals.

In recent years, private payer payment-to-cost ratios have increased faster than the average margins across all payers. As payment-to-cost ratios grow, the incentive to capture privately insured patients also grows.

On this slide we see the rapid growth that has occurred in ASCs. The number of Medicare certified ASCs does has grown from 2,800 centers in 1999 to roughly 4,700 centers in 2006. On the next slide we also see there's been rapid growth in physician-owned specialty hospitals. The growth in specialty hospitals from 2004 to 2006 may appear odd, given that there was a moratorium on new

physician-owned hospitals in 2004 and 2005. However, hospitals that were already in the process of being developed were allowed to continue with construction. The moratorium has been lifted and looking forward the incentives are set in place for more construction of specialty hospitals and more conversions of ASCs to specialty hospitals.

One question that runs through all of these models of physician/hospital cooperation and physician/hospital competition that Anne and Ariel and I have been talking about is what happens to patient volume? There has been some research on the effect of physician-owed specialty hospitals on volume. As you may recall, in our specialty hospital study we did find that the opening of a cardiac heart hospital resulted in increased utilization. With the average heart hospital, total cardiac surgeries in the market were estimated increase by 6 percent.

Brahmajee Nallamouthu also had a recent study in JAMA that confirmed these results, showing that physician-owned specialty hospitals were associated with an increase in the number of revascularizations. In addition, Jean

Mitchell and colleagues have examined spine hospitals and found that the opening of these hospitals was associated with an increased number of spinal fusion operations.

Stepping back a minute, we have some topics for discussion. First of all, is there any strategies that you think are important that we missed? Are there any of the strategies that we discussed that you would like to see us spend more time on and get more detailed information for you on? And finally, are there any strategies that could be targeted and looked at to improve value? For example, how could we create incentives for comanagement arrangements between physicians and hospital staff to focus on quality improvement and resource use and maybe less on growing market share?

With that, we'll open it up to your comments.

MR. HACKBARTH: For the benefit of the audience, let me just say a word about the context for this. A theme of the Commission's deliberations over the last year or more has been that health care delivery for Medicare patients and all others is often too fragmented, in large part as a result of the payment system. There's been interest in looking at ways that we could potentially

encourage closer, better collaboration among different types of providers.

One of the areas of particular interest has been physicians and hospitals. And so the staff have presented some background information to help inform that discussion going forward.

Questions, comments from commissioners?

DR. KANE: Just on the strategies you've missed, I don't know if you'd call it a strategy, but one thing I've noticed in running a physician executive management program is that many of them are now either chief medical office servers or VP of medical affairs in community hospitals and a lot of health system type hospitals. And their role -- it's a new role, I think, there didn't used to be these positions and they're executive or top management physicians -- where their goal is to coordinate and collaborate with the community doctors around usually quality improvement initiatives.

So I wonder if other than actively -- it's not all financial and not all ownership-type relationships. Some of these CMOs and VP-MAs are there specifically to create connections and communication and shared quality

improvement efforts. And I think that's a fairly big movement because a lot of hospitals seem to have added CMOs in recent years.

So one thing to look into would be whether the CMO or VP-MA is what they do, what their effect is, and whether or not that's improving the coordination and quality improvement.

The other place where I think administratively hospitals and health systems have been trying to incorporate physicians more is on their boards and creating subcommittees around quality improvement. There's been some research around what that has done, what kind of things do they pay attention to. But it's, again, mostly around quality improvement. But not only hospital clinical improvement but around broader community health improvement. So I would put those under kind of managerial strategies or governance strategies more than the more direct ones. But I'd be curious to know if there's any research on what their impact has been.

DR. WOLTER: This was very nicely done, I thought. I did think on the table we might want to include sort of group practices and integrated systems as one of

the models where hospitals and physicians work together. I think you do address that in the text.

One of the places, as we've talked about over the last couple of years, where this is a very, very important topic is at that intersection of high volume/high cost care. I think that is a place where if physicians and hospitals would work more closely together we could make some gains in both quality and cost, as we discussed earlier this morning. And so ways to foster that, I think, would be quite useful.

I do think there are some hospitals now who are beginning to think about -- the phrase is clinical innovation -- and how that can be focused on the IOM six aims, as opposed to some of economic joint venture approaches. But there are inhibitions to even focusing on clinical innovation, which you've addressed in the gainsharing discussion. And it would be nice, as we have recommended in the past, if we could get some relief there that would allow the right type of clinical integration and activities between doctors and hospitals to work. And around that there could be some financial arrangements between the physicians and the hospitals to do that.

Within this topic, one of the things I am concerned about the most if you look at what's gone on in the last number of years is the self-referral issue. I think that being the doctor of the patient and then the referral of the patient to something in which you are an owner does have at least a tendency to lead to increased utilization. There's past literature on that as well as the literature you have cited today. And I worry about that, although there are many reasons why physicians do move into these ownership arrangements because of the difficulty they have working at times with hospitals. And I understand that, as well.

And then I would also point out that although I think many hospitals now are trying to look at clinical integration and have very lofty goals about how they might tackle some of our current issues with physicians, there is no question that many of the joint venture arrangements they go into with physicians are to drive volume. That is the strategy.

And so as we discussed with the SGR discussion last year, if we're going to look at appropriate volume and how do we deal with the rapid increases we are seeing in

some areas, at some point I think we have to look at whether or not those hospital joint ventures that involve physician ownership should have the same focus we've put on specialty hospitals. I really worry about that.

And then I really agree with Nancy, there are some other interesting things going on that are going to be very important for the future in terms of how physician leaders are grown and become part of boards, become part of executive teams. That can really help us with this cultural transformation over the years, as well.

MR. HACKBARTH: Nick, do you think it's fair to say that some of the collaborations, the joint ventures to drive volume as an example, some collaborations are troublesome in the context of an open ended fee-for-service payment system? Whereas the same sort of collaboration may have a very different effect and dynamic if it were in a payment system where they had accountability for overall population cost and quality of care.

And so it isn't necessarily just the legal form of the collaboration but it's that plus the economic context in which it occurs.

DR. CASTELLANOS: First of all, there's a lot I could say and there's a couple of issues that I think are really -- I think it's very interesting, MedPAC specifically and a lot of other organizations always allege that the physician is the driving force behind the volume increase. It's certainly interesting to see what strategies that the hospitals are doing, too.

There's another strategy the hospital does that is not listed here and it's called exclusive credentialing. I think we need to touch on that. What that means is that they will economically credential you. By that I mean if you're credentialed to that hospital, then that hospital forbids you from using any other hospital, using any other lab, using any other x-ray. But your credentials are exclusively restricted to the use of that hospital. I think that's restraint of trade. That's been going on quite a while and I think we, as MedPAC, need to perhaps consider addressing that.

The other issues are we both, the hospitals and the physicians, have pervasive incentives. I don't know of any other business where the businessman is not patted on the back for the profit he makes. Insurance companies are

certainly that way. But there seems to be a stigma if the hospitals make too much money or the physicians make too much money.

I agree, we do need to come together, and we really do. Our incentives are not always in the right direction. I think physicians and hospitals need to make a profit, they need to pay their costs, and they need to make some extra money so they can invest into new equipment. I don't think there's anything wrong with that and that any business model would say that.

Specifically, I'm a small business person. If I'm not in business today I can't take care of today's patients or tomorrow's patients. So it's not inappropriate for me to make a profit, a reasonable profit. I didn't say an excessive profit.

And the hospitals are in the same way. So we're really almost on the same line, that we both have decreased incomes but we have increased costs. So we're almost on a collision path.

I think it's really important and it's a continuation of the discussion we had this morning about the hospitals and the physicians have to come together.

Right now we're not really even sometimes talking together. One of the issues that I was talking about with Nick before and the Commission has discussed is ways that we can facilitate physicians and hospitals working together for quality improvements, for clinical integration and, as discussed just recently, some community improvements.

I think one of the first ways to do that, as I tried to suggest this morning, is the bundling of A and B, but not just in the surgery field but in medicine, too. It gets the doctors working together. We have silos within the medical community. Sometimes one specialty doesn't talk to another specialty. But we need to start working together. We have to remember the patient is why we're there.

We need a level playing field. Gainsharing. Well, gainsharing looks good and I'm only concerned a little bit about gainsharing because once the fat is gone there's not much savings to be made until you start cutting into the bone. If we start cutting into the bone, maybe sometimes we're going to not do the best thing for the patient.

I think there are a lot of other issues that we can certainly talk about. The self-referral issue is really important. I think there's a lot of legislature going on now with Stark III and physician payment schedule. And I think a lot of that is going to be ironed out or discussed and put forth for us. But I certainly agree with what Nick said. Sometimes these are perverse incentives.

It's interesting that the hospitals can own physicians but somehow it's not right for physicians to own hospitals. I think the physician community can do a better job in the outpatient facilities. We certainly have proven that over and over again. The hospitals perhaps don't recognize that and, as I said, we need to be on a level playing field when we sit down and talk.

The real issue here is who's going to control. That's the issue in the community is the doctors don't want to be controlled by the hospitals and, likewise, the hospitals don't want to be controlled by the physician.

Thank you.

MR. HACKBARTH: Ron, can I just pick up for a second on your point about physicians and hospitals needing to make a profit to continue in existence? I certainly

agree with that and I'm certain that most, if not all, of the commissioners would agree with that. Let me just try to reframe the issue a little bit.

The concern that I have is that it's too easy for people to make a profit without producing a high quality product and being accountable for that product. The product that I'm thinking about is good longitudinal care for patients. That's what the patients ultimately care about. So the situation that troubles me is high profit, inefficient, low quality care which is regrettably too common. It's certainly not universal, but too common.

So what I want is a system where physicians, hospitals, insurance companies, and every other participant can make a reasonable profit by doing the right thing for patients and being accountable for their results. And so when I look at how can we change the incentives to encourage better collaboration, that's the goal that I'm after, reasonable profit for high quality performance.

DR. CASTELLANOS: And I couldn't agree with you more. I think the majority of the physician community totally agrees with you. We need to provide high quality care at a reasonable cost to the patient. But the

physician and the hospitals need to be paid their costs for providing that care.

I can tell you in the perverse financial arrangements we have now sometimes we don't get paid adequately. I lose money taking care of some patients. There's no question I do that. And I can't afford to continue to do that as a businessman.

DR. SCANLON: Since there are a number of economists here, let me talk about this in terms of economic costs versus accounting costs. For the economists, the costs are what it takes to get this resource to be used in this function, which may be less than actually what is paid out. And what is paid out, in addition to that economic cost, would be a profit in an economic context.

So there's a question of on the hospital side, and we might call in inefficiencies, whether the salaries that are being paid are too high or whether there's too many resources being used. On the physician side there's the issue of the compensation going to the physician. If they were paid less or could take home less, would they

still want to be physicians? That's the fundamental question.

We talked this morning about the comparison between the U.S. and other countries. One of the graphic differences between the U.S. and other countries is the compensation going to the individuals that are involved in the health care system.

DR. BORMAN: I'd like to just touch on some of the linkage between what you talked about hospital recruiting of physicians and how it interdigitates a little bit with workforce because we've touched on workforce in the last year. And I think that it represents several things.

Number one, the debt burden with which medical students and residents finish now is many times what it was even 10 years ago. These people are multiple hundreds of thousands of dollars in debt by the time they finish their residency. That's because you've got people in the 25-to-35 year old age group, they're starting families, they've got big expenses and their salaries are certainly not necessarily built to support that. So I think that there is the debt issue to start with. So these debt forgiveness

things -- I know practices, for example, not just hospitals, that will offer a partner, an incoming new partner or at least someone joining their practice, debt forgiveness as part of their package. So this is part of recruiting packages for practices, not just for hospitals. So there's that piece of it.

On the newly finishing resident side now there is also, as we briefly touched on before, something of a higher priority put to lifestyle, not only the economics you get out but what you get out in terms of time and control over your life. And certainly, some of the specialty intra- or inter-specialty redistribution that we've talked about, to some degree speaks to that as well. I think that when someone hooks up, if you will, with a hospital or a system they're putting tighter boundaries around that their lifestyle. And so that's part of the appeal here, is walking into a defined circumstance where they can negotiate some of the work variables, if you will.

Another thing is that in certain arrangements and certain states and with certain carriers being a hospital employee may affect your malpractice insurance, access, cost, exposure. So that can be a significant thing. I can

tell you that even though that's been fairly significant reform in the last three or four years in the state of Mississippi, that I know lots of practitioners who have actually become hospital employees for just that reason, that relates to their ability to negotiate a better professional liability exposure, expense, whatever you want to call it.

And then there is another piece that's not so much in the minds of the entry-level practitioner but certainly one that's moving along. And that is, it's another piece of this lifestyle control thing, is controlling the efficiency of your practice, that if you can limit your activities to one hospital, that hospital is extra responsive to you, as sort of a preferred person, that it does allow you more control of your lifestyle. So I think it does interdigitate with the workforce piece.

the other piece that I think it marries up to a bit is -- I'm not quite sure how to label it. But hospitals as economic engines in a community. To the ability that a hospital can bring physicians, it expands the economic impact for the community not just for the hospital. I think as we go down this road of where we

invest resources, how systems may be, there are some very difficult choices here about what level of resource to put at what kind of population base or geographic area.

Coming from a state where most of the population is highly concentrated in a few areas and there's lots of people thinly spread this is a very big issue. But frankly, Corinth, Mississippi does not need to be able to do the same level of care as does Jackson or even Meridian. So we've got some hard choices to build into this, I think. And I think the hospital as economic engine plays into this as well.

DR. MILSTEIN: I just wanted to speak in favor of what Glenn has now first expressed in a question and then in a statement. And that is as you begin to talk this through it's clear that restrictions that offset conflicts of interest that make sense in a fee-for-service environment become a barrier to progress for those providers willing to assume accountability for reducing Medicare spending and improving quality.

And so where that pushes me on this would be in the direction of even tighter conflict of interest protections for providers who have not assumed such

accountability and removing such restrictions for providers who haven't been willing to assume that level of accountability for total send and quality improvement.

DR. CROSSON: Very similar comments, and also similar to some of the comments that I made this morning in a slightly different context.

If we look at the last question in the presentation, how could the strategies be transferred or targeted to improve value, I'm not sure I really would call them strategies. These are more simply the range of forces that are at play at present. And they are presented dualistically but there's a range of things there, as opposed to necessarily conscious strategies.

And I think we've talked about two areas. One, of course, is the issue of the payment methodology. So a lot of these strategies or these observations of what's going on are a function of various entities perceiving what their economic self-interest is. And it may lead to the creation of a specialty hospital because of perturbations in DRG payment or whatever. But they tend to track to the payment methodology and then the perceived self-interest of that.

So clearly one way of targeting is to develop some method of linking accountability between the physicians and the hospitals for the volume and intensity of services, particularly those technical services which are discretionary where there seems to be the largest increase of volume of services going on, and also for the quality of care. So the same notion.

The other one again, the other targeting, would seem to me would be on the issue of governance and management. We simply can't encourage, it seems to me, the throwing together willy-nilly of doctors and hospitals in the way that occurred in the 1990s because we're likely to get the same result, which is some things that worked and some other things that didn't work.

I also believe, as some others have said on the commission, that we really don't want to encourage a world in which the physicians are in some way pushed into a subservient relationship with the hospitals. First of all, it isn't going to work. It's not a strategy that will be accepted and will be successful. And it's not right, I don't think because the physicians have at least as much to

bring to this table as individuals who are responsible for running the hospitals.

The problem is we don't have very successful models of how that would work. I think sponsoring the development of such models, helping in the creation and support for a period of years of such models, perhaps linked to new methods of payment, perhaps those new methods of payment will need some forgiveness in the obstacles to shared savings, begins to create the parameters of some work that needs to be done.

So creating the shared savings opportunities, if there's flexibility needed in the regulatory environment, combined with a payment methodology that makes more sense and links the accountability of the physicians and the hospitals together and then explores ways to do that in a way that works both for the hospitals and the physicians in a modeling sort of sense.

MR. DURENBERGER: I really like the way in which this is laid out and the way in which it's presented. And it's a compliment to Mark and the staff and the people who have worked it.

I feel much better going into this part of it than I did when it was what do you think of specialty hospitals or what do you think of surgical-owned hospitals. Because this looks like a learning experience for all of us. I really value that. I value the way you've presented it in terms of relationships and in terms of competition, what are the values of competition? What are the values of collaboration? And so forth. I think that theme is really very, very important.

But as I listened to the discussion, I'm reminded of the fact that all of this is premised on that researcher named Rohmer, who said once upon a time if you build a hospital, the docs will fill all of the beds, and that sort of thing.

I remember my own pride about two or three years after we passed the DRG legislation and it was being implemented. I'm quite sure I was in Phoenix and I was riding from the airport into town or something like that. And I saw all these billboards advertising these doctor practices and that sort of thing, all of them were benefitting from the fact that we passed DRGs and now you could do things in your office that you didn't use to do

somewhere else. In my egotistical mind I was taking credit for all that sort of thing.

So here we are.

Approaching this though, I want to add just one dimension to this. And that is if we approach this the way most Americans would approach it, they think about medicine and this whole subject as a zero sum game. Like everything that is done is medically necessary. Whether it's my interface with the doc or my admission to the hospital, it's medically necessary, it has to be.

We know different. We know different. It's not a zero sum game like it is every other industry. And this one, for all the reasons that my various of my colleagues have articulated, there is really almost no end in sight.

We've been doing, for the last year and a half, an exercise out in Minnesota called the medical arms race syndrome, trying to identify the syndrome, what's the probably with it, the infection. Basically it's that medical technology and capacity of everyone, Ron and everybody else, is growing faster than our local systems capacity to adapt it to the value that patients deserve.

So in thinking about this and premising it, I think we should direct some of our attention to the issue of over treatment. I'll just quote from this piece that Jack Wennberg will have published in Health Affairs in a couple of months. "Clinical decisions are inevitably driven by the availability of resources, which is determined in large measure by local hospitals' decisions," et cetera, et cetera, et cetera. You know the Wennberg work.

I just think it should be somewhere up front in what we do we ought to articulate that as a reality. Because over treatment, and Sharon Brownlee is doing a book for the New America Foundation, which will be out in a month or so, entitled Over treatment. You can read -- mainly it's Wennberg's work and Elliott and everybody else. But it's got specific application so that you can look at it and you can see what we are doing to ourselves as patients by not dealing with subjects just like this.

So the bottom line is not this is good guys/bad guys, physicians versus hospitals, any of that sort of thing. I think putting it in this very positive context, which is how do we learn what's really going on and why and

what are the economics, what are the policy failures and so forth should help us a lot in coming to the decisions we need to come to. But the premise needs to be we are trying not just to improve the costs of the system. We're trying to do something about the impact on the health of Americans, whose health is at risk because of this growing over treatment that comes from having too much technology available.

MS. DePARLE: I wanted to follow up on really some of the things that Karen was talking about in her remarks earlier.

I liked the way this was organized, too, because it set things out in a very coherent fashion. And as Dave said, it wasn't presuming that we were trying to answer some question much bigger than just what are the arrangements and how are they structured.

The one that interested me the most was the employment model that seems to have grown quite a bit, 10 percent or so in the last few years. And Karen, I think, pinpointed some of the reasons why that might be happening.

But to bring it forward two Dave's question, and this may be way too granular based on what data you have,

but you make a statement about the data on the impact of employment on volume is mixed or sketchy or appears to vary I guess is the phrase you used.

I had a little trouble following this really, what do we know about that. But to move it beyond just volume, do we know anything more about the impact of employment on quality of care or on overall spending as opposed to just volume? Of course, what one would like to see is that the physicians in this relationship, perhaps even without some other overt financial incentive, might be more closely aligned on the same page with the hospital and might be more inclined to perhaps provide more care for certain conditions and less for others just based on clinical reasons.

Again, you may not have the data.

MS. MUTTI: I haven't looked at it in great depth but I did pick out one or actually two sites that did find that physicians that are employed by hospital systems, HMOs, other things that have this kind of integration are more likely to engage in care coordination activities. So that's one step along those lines. We can certainly go

through the literature a little closer to see if there's more indications on that.

MS. DePARLE: I'd be interested in us looking at it a little more. I've heard about this anecdotally around the country and I guess I've assumed that it was more likely to be occurring in rural areas. But I'm making that up. I don't know. I'd be interested in where is it occurring? And is it an opportunity? The trends that Karen cited as a some of the reasons for this development seem to me to not be temporary phenomena. They seem to be things that will continue.

So is there an opportunity to take this phenomenon and make it into something more that we want to see as a result, the accountable care organizations, whatever? What would it take to accelerate it, if that's the case?

DR. BORMAN: Could I just add, and I don't know that there's a way to look at this. But one of the things that I wonder in this, particularly on the hospitalist side is one of the models of the employed physician. And I think the data are probably mixed and very local specific. But you can see where there might be advantage to inpatient

care and potentially to quality, although I think the biggest press is to help move those patients through the hospital more quickly, frankly.

But what is the downstream effect? Because it does actually sever the bond across to the post-hospital care. And I will tell you that there's a growing movement, at least in general surgery, toward the surgical hospitalist. And I think we need to maybe have some sense of what the downstream is. And as Nancy-Ann points out, figure out what kind of relationship or trend we might want to encourage.

MR. HACKBARTH: At an American Board of Internal Medicine meeting that I was at recently there was a fair discussion of hospitalists and the pluses and the minuses and it's effect on coordination of care after discharge as a area of particular interest and concern.

Another topic, I think it was at that meeting, some data was provided on where physicians are practicing. There have been some shifts in that. The proportion -- I can't remember the exact numbers -- but the proportions in solo or very small practice have begun to decline.

Also interestingly, the percentage in large multispecialty practice have also declined relative to where they've been. What's grown is that middle, single specialty group is really where the rapid growth has been recently.

DR. DEAN: Some of this is sort of restating, but I would certainly, just to follow up on what Karen said, I think that we clearly need to broaden the perspective so we don't look just at a hospitalization but look at the broader care and the follow up. I guess the discussion sort of brought to mind the old adage that every system is perfectly designed to get the results that it achieves. As that's what we've done. We've created a system with a lot of perverse incentives in it and we're getting a lot of perverse results.

So the issue is how to realign those incentives. Obviously it's not easy. But it seems to me that, as Ron said, maybe an approach that involves some bundling so you put the financial incentives together, hopefully you could overcome some of these conflicts because they clearly happen. He mentioned the silos. I encounter it all the time, of silos even within the medical profession. I refer

patients for evaluations and they see three or four specialists and the specialists clearly don't talk to each other. And they come back to me with conflicting recommendations and conflicting regimens and overlapping treatments and a lot of stuff that they clearly can't follow up on.

And so somehow we need to get people's attention that there is value in collaboration. That's probably restating the obvious, but it's something that I find very troubling and have found more troubling over the last few years. It seems to me that just intrinsically as physicians if we're interested in really helping people, we have to work with hospitals. It seems to have declined. I find it very troubling. But like I say, I don't have an easy solution but it's clearly the direction we need to go.

MR. HACKBARTH: We're disappointed in you, Tom, that you didn't come to the commission with a solution to that.

DR. DEAN: I'm getting more confused as time goes on.

MR. HACKBARTH: Join the club. You should go right at home then with us.

MS. HANSEN: In looking at the question on page 17, does the increase in volume improve health is one of the questions that I think that we kind of keep going back to. All the places that build, and we have an increase in health of course, build them and we should fill them type of things. In some ways it's not unlike a hotel. You always want to have full occupancy with good paying customers.

But the whole question of do we really get the quality of results based on volume, I wonder whether there is any value in overlaying the whole aspect of some of these high-cost areas that we traditionally know about, whether it's the Florida, the Southern California, those kind of markets, whether there's any pattern that also starts to compare to the lower cost areas that have less volume but health status indicators.

To just kind of tease up more of the question of what do we get for the volume of use on some of these arrangements that we're talking about, whether it's the specialty hospitals or whether it's the hospital/physician arrangements. Is there any correlation or patterns that can be discerned from just the high cost areas themselves?

I don't know. I'm not asking that it be done. It just might be a question to take a look at. There's something funny here that I certainly can't grasp but a lot of use.

DR. MILLER: So is the question, just to try and tease it out, is the question if you look across these kinds of arrangements that are occurring in the industry, do you see any correlation between high and low cost areas and the existence of certain types of these relationships?

MS. HANSEN: Right.

DR. MILLER: Jeff and company have established a relationship between the existence of specialty hospitals and volume. But you're asking about the other arrangements? MS. HANSEN: Right. So in other words, have we done anything different? I have a hypothesis that's not tested but when we looked at, and I had an opportunity to actually be with Kaiser for a quality session. Elliott Fishman was there, as well.

I think Kaiser are also found that even the practice within Kaiser, which is already a consolidated model, had some differentiations in some of its lower cost communities like Oregon, as compared to Los Angeles. It's

still Kaiser. But I just wonder if there's some geographic cultural patterns, as well.

MS. THOMAS: Certainly Fisher has looked, in the Medicare fee-for-service data, at state variations in spending and the relationship between quality measures. It doesn't overlay these relationships per se but the relationship is negative or neutral depending on the state you look at. So the higher the cost doesn't seem to buy you higher quality.

DR. REISCHAUER: But Anne, are there strong geographic patterns to these relationships? So if you went to LA they're all doing recruitment? Then you went somewhere else and they're doing -- isn't it just...

MS. MUTTI: Not that I've found yet, because we kind of thought it would be nice to research what would be the actual effect and we haven't figured out how to identify a market that does all of these things and isolate their effects.

DR. MILLER: There was also some work in the Commission a couple sessions ago, which I can remember and can't dredge up very well. But we can do that. When Cristina was looking at the relationship between the

formation of groups. I can't necessary pull it up but we can also try and pull that into that.

Because I think what you're asking is do you see any correlation between these kinds of arrangements and some of the utilization of services that we're seeing across the country. We can try and look into that. But I suspect that it's very hard to know -- to have a comprehensive measure of how these relationships exist across the country.

MS. HANSEN: Again, it's just not the relationship but the health of it. Do people need a lot more -- I mean the population dictates more orthopedic surgery or CABGs in certain areas. So it's like is there real justification clinically for these kinds of things? I don't know if there's a way to be able to understand that.

It says in our study of specialty hospitals that if you have a lot of heart hospitals then that market will increase with cardiac stuff by 6 percent. So it's kind of build it you will find it and you will make it happen type of thing.

DR. WOLTER: There are a couple of other things that occurred to me after Ron said doctors owning

hospitals, that might be policies we should look at. One of those is the sort of safe harbor area and the group practice exception area. I am aware of a hospital owned by a multispecialty group practice and none of the physicians would have more than say a percent ownership, per se, in it. And they probably have a compensation model that's really based on using MGMA or MGA benchmarks, which I think blunts the self-referral issue. And yet they could run into trouble with that integrated approach to health care with what's in the current House bill, for example.

So that's just another area that we might want to look at in terms of policy.

And them I'm aware of another hospital sponsored venture with their physicians where it's a whole hospital truly, in terms of broad array of services. No physician is allowed to have more than 1 or 2 percent ownership. But they feel it has created some accountability around looking at quality and cost.

And so are there some models like that that from a policy standpoint we might want to look at that maybe don't quite get to the level of ownership where the self-referral concerns are as big.

MR. HACKBARTH: Okay. Thank you all.

The next item on our agenda is increasing participation in low income programs.

Before Joan begins, let me just say a word about the context for this one, as well. You'll recall that when we discussed MedicareAdvantage, and even moreso when Congress discussed MedicareAdvantage, one of the issues that came up was whether low income beneficiaries were, in particular, dependent on benefitting from the added benefits offered through MedicareAdvantage.

We're not going to go into the statistical debate about whether there is disproportional enrollment but it did seem to us that that raised an important question which is are we effectively reaching low income beneficiaries through the traditional Medicare program and the supplemental methods? I think most commissioners know the basic answer, that is probably not because the enrollment, the participation rates in these programs is pretty low.

And so Joan is going to review some of those data plus some information that we've gathered about potential causes and information from a site visit that's relevant.

DR. SOKOLOVSKY: Good afternoon.

Congress has established a number of programs to provide financial assistance to Medicare beneficiaries with limited incomes. Although programs like the Medicare savings programs provide significant savings to eligible individuals, the majority of eligible beneficiaries do not participate. There are many reasons why individuals might choose not to take advantage of these programs, but researchers have found that the main barriers to enrollment are beneficiary lack of knowledge of the programs and the complexity of the application processes.

Today's presentation focuses on the Medicare savings programs and a low income drug subsidy. We're looking for your feedback on the direction this work should take.

In this presentation I will briefly describe the Medicare savings programs and the low income drug subsidy. I'll review reasons for low participation in the programs and compare the two programs with a particular focus on state of flexibility in the administration of MSP.

Finally, I will discuss early findings from a site visit to Maine. This is a state that has been very

active in finding ways to increase both MSP and LIS enrollment and using some very unique techniques.

There are three main Medicare savings programs. The benefits for belonging to these programs include payment of the Part B premiums and, for QMBs, payment of Medicare deductibles and coinsurance for Medicare covered services. In addition, anyone involved in a Medicare savings program is automatically eligible for the Part D low income drug subsidy.

This chart shows the eligibility criteria for the three programs.

QMB and SLMB I should say are financed through the federal government and the states at the Medicaid matching rate for each state. Some QMBs qualify for full Medicaid benefits but here we're only talking about the group, sometimes called QMB-only, who get these particular Medicare services.

QI or qualify individual is a block grant program that's furnished entirely by the federal government and that's for individuals who meet those income and asset criteria.

As I'll talk about later, states have considerable flexibility in using these criteria. For example, when they count assets they decide whether to count assets like cars or life insurance policies. Some states disregard all assets. Similarly, when they count income, they may decide to disregard certain types or amounts of income.

This slide shows the eligibility criteria for the low income drug subsidy or LIS. The subsidy provides coverage of Part D premiums for qualifying plans, deductibles, and limits cost sharing depending upon beneficiary income and assets. Importantly, beneficiaries getting the low income drug subsidy face no gap in drug coverage.

As you can see, there are two ways to receive the subsidy. Beneficiaries can apply directly for the subsidy and demonstrate that they meet the federal income and asset criteria or, if they are dually eligible for Medicare and Medicaid or enrolled in any of the Medicare savings programs, they will be deemed eligible for the subsidy and be automatically enrolled in a subsidy eligible plan if they do not choose a plan for themselves.

Because data on assets are so limited, it's hard to get a good sense of the total eligible population. This chart is based on CMS's estimate that 13.2 million beneficiaries were eligible for LIS in 2006. CBO estimated that more than 14 million beneficiaries were eligible at that time.

As of January 2007, 50 percent of those eligible for LIS or 6.9 million beneficiaries were deemed eligible and got the subsidy. Most of these were the dual eligible population. 17 percent or 2.3 million individuals applied for LIS and were found eligible by Social Security Administration. CMS estimates that 3.3 million or 25 percent of the eligible population are not receiving the subsidy.

So the question is why don't more beneficiaries participate in these programs? For MSP, as for other means tested programs for the elderly, less than half the population that's eligible for the programs sign up and participate. Analysts estimate that about one-third of those eligible for QMB, not counting duals, are enrolled and only 13 percent of those eligible for SLMB.

Participation in the low income drug subsidy is higher. Somewhere between 35 and 42 percent of those eligible to voluntarily apply did so successfully. Again this is not counting the dual population.

Analysts suggest many reasons for the low participation rate but one evaluation of the MSP program found that almost 80 percent of the eligible non-enrollees had never heard of the programs. Even some state Medicaid workers and other outreach counselors hadn't heard of them.

In addition, advocates believe that the complex application processes, both to enroll and then to retain enrollment the next year, lower participation rights. About two-thirds of those enrolled in MSP needed help to complete their applications.

Finally, eligible non-enrollees tend to be more isolated. They could be homebound, live in very rural areas, or have cognitive difficulties, all of which makes them very to reach with information about the programs.

While LIS is a federal program, MSPs are combined state/federal programs administered by the states. In general, federal income and asset criteria, as you saw in the earlier slide, for LIS are higher than for the Medicare

savings programs. For example, the asset limit is higher for LIS and only liquid assets are counted. While individuals must have incomes below 135 percent of poverty to qualify for MSP, individuals with incomes of up to 150 percent are eligible for some assistance under the drug subsidy.

Beneficiaries may apply for LIS at either Social Security offices or at state Medicaid offices while states administer MSP. Some believe that allowing application at Social Security offices reduces the perceived stigma of applying for help at a Medicaid office.

However, states have considerable flexibility to adjust federal requirements for MSP, although they can't set criteria that are more stringent than the federal standards. And anyone who applies for LIS at a Medicare office must be screened for MSP as well. If it turns out that they're eligible for MSP and they go to a Medicaid office, they will get both.

Further, anyone who's enrolled in MSP is automatically, as I said, deemed eligible for the drug subsidy no matter what the income or their assets. This means that beneficiaries with similar income and assets may

qualify for LIS in some states but not others, even though LIS is an entirely federal program.

In administering MSP, states must weigh their desire to provide more assistance to residents with limited incomes with their need to balance their budgets. In other words, there's a trade-off between increasing beneficiary access and increasing state spending. So, as with the Medicaid program, there's a lot of variation in how states determine eligibility and administer the programs.

For example, some states have eliminated the asset test for some or all of the MSP programs. And eliminating the asset test is important, not so much because it increases the number of people who would be eligible but because it generally reduces the amount of documentation that beneficiaries must provide with their applications and that makes the application process simpler.

Some states exempt more types of resources for consideration of MSP. For example, some states may not count life insurance policies up to a certain level. States also differ in terms of the stringency of their

administrative requirements. Do you have to go in person to an office to apply or can you mail in an application?

Some states want original documents to prove eligibility while others will permit copies of documents. Some states have developed simplified applications in recent years. And in addition, states vary a lot in how much outreach they do to find eligible beneficiaries and enroll them in the programs. But in general researchers find an increasing amount of outreach over the past decade.

In the past decade there have been a number of public and private campaigns to increase participation in MSP. Most have achieved small but meaningful success. For example, in 2002 the Social Security Administration began notifying beneficiaries about their potential eligibility for MSP. GAO did an evaluation of this and they estimated that SSA mailed letters from May to November 2002 to 16.4 million potentially eligible beneficiaries and that contributed to enrollment by 74,000 additional beneficiaries.

More recently RWJ and the Commonwealth Fund sponsored grants to five states to increase MSP participation. We don't yet have a complete evaluation of

these projects but MSP enrollment in all five of these states increased. Data suggests that the most successful outreach programs carefully targeted eligible individuals and gave very specific information on how and where to get help if you wanted to apply.

Policymakers and beneficiary advocates have suggested numerous changes to increase participation in both MSP and LIS and in future work we plan to examine these options and describe their advantages and disadvantages.

Here I want to talk to you about a trip we made to Maine. The state of Maine has been very active in efforts to increase participation in both MSP and LIS. It has a long history of coordinating efforts among different state offices and of working closely with community groups. In 2006 and 2007 the state initiated a major campaign to increase enrollment in both of these programs. With contractors from Georgetown University and NORC we conducted a site visit to Maine to discuss policy changes with state officials, beneficiary advocates, and beneficiaries.

In 2007 Maine broadened MSP eligibility in two stages. First in January it effectively eliminated the asset test. And then a few months later, in April, it raised the effective income limits to coincide with limits to their state pharmacy assistance program, which they call DEL. DEL provides coverage for drugs for up to 185 percent of poverty.

The state then autoenrolled all DEL members into MSP in April. This meant that they were then deemed eligible for the low income drug subsidy. Here you see the results.

As anticipated, enrollment in MSP increased substantially, from almost 9,000 in January 2006 to more than 30,000 by July 2007. Again as you see, the largest increase occurred in April when the new income limits went into effect and the state deemed the DEL enrollees eligible for MSP and LIS. About 13,500 beneficiaries were enrolled in that one month.

Officials found that the new income eligibility limits of 150 percent for QMBs turned all of their previous enrollees in the SLMB or the QI program into QMBs. With a shift of so many enrollees into LIS, the federal government

now covers a substantial part of the costs of providing the drug benefit for DEL enrollees. But at the same time, the shift into the QMB program means that the state Medicaid program has added costs, principally the premiums, the Part B premiums, and the deductibles for the new QMBs. Costs for copayments are likely to be modest. Remember that if the Medicare program expenditure, the 80 percent of the payment usually, at least on the Part B side, is higher than the full Medicaid payment rate that that can count as payment in full and the Medicaid program doesn't have to take on any additional costs.

Although as you can clearly see, most MSP enrollment increased because of the deeming of the DEL enrollees, state outreach across this two-year period was also a factor. Advocates tell us that publicity about Part D made more people aware of the programs. They found when they first began to talk about Part D and the low income subsidy the national slogan of you can get extra help didn't work in Maine. But when they started talking about you can save money, that one resonated much more clearly. And this seemed to be much more accepted in the community.

Our respondents believe that the eligible population that is not enrolled in either MSP or LIS is primarily the most isolated and hard-to-reach population.

Moving forward staff seek your input for the direction of future work. Some of the possible questions include should the state criteria for MSP administration and enrollment vary? Secondly, to what extent can federal policy affect participation in MSP and LIS? Given the difficulties of reaching the eligible and not enrolled population, what strategies would be most effective? Just to give you one example, should federal resources be used in media campaigns to promote program awareness amongst the widest group of potential enrollees? Or to support state one-to-one outreach and counseling for beneficiaries?

That completes my presentation.

MS. HANSEN: Thanks Joan, for covering this topic. I certainly find it really important because part of MMA was really to focus on this population as a major prevention.

First of all, I have a question and some comments. The question I have is with the people who oftentimes are very difficult to reach and wouldn't find

out about these programs, when they end up perhaps showing up at the hospital, at the point of say coming in for an emergency visit, do the hospitals by chance take that opportunity to sign them up for some of these programs? This is more of an informational clarification.

DR. SOKOLOVSKY: Particularly before some of these newer outreach strategies, that was one of the main ways in which people were enrolled, when they entered the hospital.

MS. HANSEN: This continues on as a whole?

DR. SOKOLOVSKY: Yes.

MS. HANSEN: That's one thing because it seems like, especially with homebound, isolated people, when people get frail enough obviously they come into contact with the system. Again that's again when people have that crisis.

The other aspect is the three questions you have here is should state criteria for MSP administration and enrollment vary? Hypothetically I would say no. It just would be nice to have a consistent system. But since we have Medicaid variation, I understand that that's always going to be a degree of complexity.

And the ability to have federal policy affect MSP and LIS, it would be really nice to have this in some way more uniform relative then to your third question, is perhaps we should still take advantage of the Social Security office because there's less stigma that's attached to it as compared to oftentimes how people feel they may be treated when they go to a Medicaid office.

So the ability, the fact that we have 17 percent of the population successfully doing it through Social Security offices seems to be a good thing.

The other aspect of this is the whole aspect of whether or not the federal government should do some different marketing. I'm intrigued by the fact that even the framing of the idea that you could save money versus that you are qualified for a social service really has a very different kind of opportunity of again dignity that one has that you take better control of your life. So some aspect of that marketing, whether it's on the federal with some funds to guide the states in how to reach out to people.

I believe there's an effort in -- or actually there's room in MMA that I learned, that there's something

called the ability for getting leads data, to be able to plumb the Social Security information in order to find out who might be best qualified for this so that we can find people. My understanding even though it is authorized in the MMA, the inability to use this because of more the privacy issues and administrative complexity.

If there's a way to get through that barrier, again so that we can reach people, I wonder if that's something we can talk about relative to CMS being able to kind of get through that barrier? Because the intent is really to have this group have that benefit.

And then, finally, I know that I've heard from my AARP colleagues that one of the things that this whole asset test, the complexity that you brought up, is a real big issue. Given the population we're talking about, I think there are rare people who have millions of dollars stashed away. But it's talking about trying to figure out how to quantify the value of your insurance policy, these are not big dollars. But this has become such a huge barrier, even for people who are very forgetful or don't know where their papers are filed. It really makes it a barrier. So if these are some barriers that we can help

point out could be overcome, would be a real helpful way to get more people enrolled.

Thank you.

MR. EBELER: Thank you Joan, that was a nice job. I had the advantage of participating in a National Academy of Social Insurance study and report on this subject and I sort of reflect on four lessons we drew out of that. One that's sort of important.

You mentioned in your draft paper a little bit about how it matters for access. Including a discussion in this about why getting these people enrolled is important for their access to care strikes me as a critical piece of this. And the data are that folks who are eligible but not enrolled are more likely to report financial barriers to access than others.

Second, I think particularly in context of the other things that we're doing in looking to reduce the growth rate in Medicare spending, particularly important to pay attention here. If you look at the Part D program as an example, that Congress took the luxury of imposing very high cost sharing in general in that program, but with part of the policy rationale well, we're not going to apply that

for the low income. That policy rationale only works if you actually go find those people and get them enrolled. So it just strikes me that the reason for focusing on this is increasingly important these days.

The third thing is a lesson we drew out of our panel, and I think you also see it in some of the SCHIP outreach and enrollment processes, is that outreach and marketing is important and a way to do stuff. But it's very hard to sustain. It is administrative processes and simplification that is the sustainable change, because I can stop the outreach. And if I keep pouring people into a system that is almost impossible to run, they get frustrated.

Finally, there's really two kinds of administrative complexity here. One is administrative complexity within this design, which is what sort of the short-term fixes are, this dance among Social Security and CMS and the states and barriers that are put up deliberately and not deliberately. This is very, very hard to do if you're a caseworker out there. The caseworkers turnover once a year. This is just grindingly hard work.

Which leads to the second complexity that we took it to, and I think it sounds like what they did in Maine, which is program complexity. Between 99 and 150 percent of the federal poverty level there are, I think, four MSP income cutoffs, resource, different cost sharing levels and three LIS levels. That's pretty granular policy.

Each one of those categories came about in a logical way in a budget reconciliation process at one point, but you step back and part of it well, there's administrative complexity. But part of what we concluded and would challenge the Congress was could you maybe simplify the program itself and collapse some of those so that a human being somewhere could actually describe it and implement it.

I won't do it here but I have, in other audiences challenged anybody, without looking at the charts, to describe all those levels. Nobody can do it.

It sounds to me that that's part of what Maine did, is that they basically took the QMB level up to 150 and said this is a benefit. Then you couple that with simplification, no asset test. And you couple it with outreach. You can get results.

So those are just four lessons from another panel. MR. HACKBARTH: There's the notion in statistics of type one and type two errors. You're going to make some errors whenever you run big programs like this. Often the question to me is where do you want to make your mistakes?

And here it seems like we've developed administrative requirements and statutory requirements that the cumulative effect is bound to mean under enrollment and that you're going to make your errors in terms of not getting people in who the help. When maybe what we need to be doing is changing the mindset. Maybe it wouldn't be the end of the world if a few people with large insurance policies got through the gate. But we've got a much higher percentage of people truly in need in the program. We just sort of have to change our mindset.

DR. REISCHAUER: Everybody in this room might agree with that, but the politics is just the opposite. It's the one welfare Cadillac person that destroys the whole thing.

DR. STUART: But this isn't the welfare Cadillac population. These people just don't change in terms of their economic structure. So if you find them ineligible

at one point, the odds of them being continually eligible over time is extremely high. So I think your observation is a very good one because I think the cost of making errors in terms of redetermination is relatively low.

I have a couple of questions though, Joan, about your chart, if you could put that back up, the one showing the change in eligibility.

It looks like, if I'm interpreting that correctly, that the reason that the all MSP line went up was essentially transfers. In other words, they made the differential eligibility rates. So people that were in one program now are in another program and that there is this bump up.

There's clearly that. Plus, there are new people coming into the program. But it looks like it's a one-time shot.

So what happened after May or April? Why wouldn't that continue to go up?

DR. SOKOLOVSKY: Remember, the people who went in in April didn't get in because they send oh, the income has changed, now I'm going to go enroll. The state did this for them. It was autoenrolled. We actually had

beneficiaries in the focus groups that we had up there that still didn't know they were in the program but they knew they were getting an extra $93 a month and they thought it was -- you know, I can buy a pair of shoes now.

DR. STUART: That leads to two questions. One is that you think that there would be some information leakage out there, that some people that didn't know about it now are being told about it because God, this is such a good deal. That's the first thing.

The second thing is does Maine have any idea about how many people who are putatively eligible under these new criteria but not enrolled?

DR. SOKOLOVSKY: I can answer the first part of the question, which is that the counselors told us that yes, it was having that effect but slowly. That people are saying hey, my neighbor is now getting this. Also, that helps reduce the stigma, hey my neighbor is getting this extra $93. Am I eligible for it, too? But that was happening on a very one person/one person level. So you certainly don't see it in the chart.

And the other thing, it actually looks like it goes down a little bit in July. And part of that is

because of the retention issue. Each year you still have to prove your eligibility.

In Maine they tried to make it simple by saying we'll send you a letter and you just have to sign it and send it back, and that will say nothing has changed and so I should still be in the program. But even amongst the counselors we talked about there was some confusion about whether you actually had to sign it and send it back or not. So they think that they lost some people that way, who just saw the paper and said okay, and put it away.

But as far as the total potential eligible population, I don't know that. I assume it's even harder to figure that out on the state level than it is on the national level.

DR. STUART: But maybe if you did a survey of all the lobster shacks up on Route 1, you'd be able to...

DR. MILLER: Joan, you're not going to be making a field trip.

DR. SOKOLOVSKY: I'm allergic to lobster.

[Laughter.]

MS. BEHROOZI: Actually, what people have been talking about in terms of those who are eligible who

haven't enrolled, there's a big assumption implicit in there that eligibility as it's currently defined is the people whom Glenn referred to when he said the people who could use the help. In Evan's paper he cited a Kaiser Family Foundation statistic that in 2004 roughly half of all Medicare beneficiaries had family incomes of less than 200 percent of the federal poverty level, which for a family of two at that time -- looking elsewhere in the paper -- looks like it was slightly over $20,000.

In New York City that's a meaningless number. I think in lots of urban areas around the country that's a meaningless number. Taking federal poverty level as some talismanic threshold, even 125 percent of that or whatever, just is not going to get to all of the people who could use the help, as you said, Glenn. I do think it's about changing mindset and deciding how we're going to address the fact that half of Medicare beneficiaries really have very little income. And these asset thresholds of $4,000 and $6,000, forget what you count toward it. What is $4,000 or $6,000? You can spend that it all in a year and not make a dent in your medical burden. And then you have no assets and then you're really destitute.

So I think that yes, we should allow state variation the way it is now above a threshold that the federal government sets that's a lot more realistic than looking at the current poverty threshold or asset thresholds.

And again on the subject of changing mindset, when policymakers decided that it was important for people to be registered to vote in certain states they enacted motor voter laws. So when people went to get their licenses renewed or registered their cars the DMV workers were required to ask people whether they were registered to vote. So the notion that there are Medicare workers who don't even know that these programs exist, much less that they are not required to see if people are eligible even under the existing standards, it means we are absolutely in the wrong mindset, that we're trying to get people away from this stuff. Whether it's Medicare workers, whether it's Social Security, whatever federal program workers there are out there, this should be part of their regular rap.

DR. CROSSON: I thought it might be useful to shed a little light on a couple of the questions that have

been asked by discussing the program that we put in place in Kaiser Permanente in 2006 to try to identify among our Medicare population those individuals who were eligible for the low income drug subsidy.

So we developed the project with the National Council on Aging and used a modeling tool and applied it to our population of about 800,000 Medicare members. It was primarily driven by -- there were a number of factors in the tool but it was primarily driven by age and ZIP code to try to make an estimate of individuals who might be eligible. We ended up with about 80,000 or about 10 percent from that group.

We ended up then developing a communications center, a call center. We sent out a mass mailing to those 80,000 individuals and then followed up with telephone calls. Everyone who called back, who wrote back, and those individuals who did not call back, in an attempt to get through to them.

The first thing we learned was that despite all of that effort, we only ended up with about one-quarter, or 19,000-some individuals who would interact at all with the process. That was despite multiple connections. Of those

individuals, after extensive interviewing -- and one of the complications is that the first thing you have to do is because of CMS regulations is you have to ask the individual to call you back. You cannot elicit personal information on what's called an outgoing call. So that's the first barrier.

Largely because of that, we only ended up with in that group a little more than half, or 10,000, or 13 percent who actually, based on the interview process, applied for the low income subsidy. And out of that group about 25 percent or about 2,700, or 2,700 out of the original 80,000 targeted -- remember three-quarters of whom had not interacted -- actually ended up enrolled. The estimate is by the middle of this year we got another 10 percent of that group, or something close to 3,500 people enrolled.

When we went back then to the folks who had done the project and said to them what do you think works and what doesn't work, they felt two things: that anything that could be done to stimulate inbound calls, through advertisements, through working with community organizations, to get people to call in to avoid that 50

percent loss when we actually asked them to go back and they didn't call back -- so leading to one touch with the individual -- that would promote a much better result.

The second thing was we had a small number of individuals who were not actually accessed through do the mailings or the phone calls, but had been referred from within the delivery system, identified by doctors or nurses or pharmacists many times, and given information and asked to call the center. In that group the acquisition rate and the ultimate success rate of the application was very high.

So the two things they said was do anything you can do to get the potential individual to call in. And then anything you can do to utilize individuals within the delivery system to identify, usually on a trusted relationship basis, individuals and then encourage them to call in. Those were the two takeaways.

DR. DEAN: I just had a question. I don't think you mentioned it. Is there any reliable information about the demographics or actually the location of these folks that are not enrolled, especially rural versus urban and so forth? I would guess there probably is a difference.

Certainly the support services in my area are pretty skimpy. If that's indicative, I suspect -- I mean the support service to help with enrollment and those sort of things. I'm just curious, do we know is that true nationwide?

DR. SOKOLOVSKY: I can find out, in terms of the actual numbers. I don't know it offhand. But I do know that when we talked to the workers they mentioned how hard it was in really rural areas, just on the sense of if I have 10 workers and I can send one of them into the city and they can be almost assured of an audience of say 200 people to listen. Whereas if I send them out into a rural area, there isn't a center where they can go. It's much less cost effective.

And what they thought would work best in rural areas -- and this was just off the top of their head, I don't know that it was experience so much as what they believed. And since they were doing it every day I took it quite seriously. They thought that the best way to reach the rural population was with very well framed mass media messages that would tell people about it and give them very specific directions about where to get help, who to call.

And the person they would call would be local. And then the local people could then arrange either to meet them at a central area or even sometimes house calls.

DR. DEAN: I think that's appropriate because certainly, following up on our experience with Medicare Part D and the difficulty we had to get people, some people are just afraid of the process.

DR. KANE: Just a couple things. One of them is that the local person -- one of the things we learned in health communications is one of the ways -- I can't remember which health intervention they were working on. But one really effective way to get to people, get a message to people and have them act on it, is to work through beauty parlors. So maybe you need to enlist beauty parlor operatives in being that person who made the call.

DR. REISCHAUER: Low income people?

DR. KANE: Yes. They still get their hair cut, the ladies in particular. Barbershop, too. It's not expensive to get your hair cut. Most of them aren't still doing it at home.

But anyway, that was something that the health communication interventions people say is a great place to go.

On a broader issue, given that states have to pay part of this, I'm astounded that Maine, having worked there and knowing what their budgetary situation is, I'm astounded that they're trying to get more people into anything that the state has to pay more money for, although I understand why and I know the people are going to do it. I don't know where they're going to find the financing for it. They're still having a huge battle over how to finance their insurance subsidies for working people. God help them.

I don't know if you asked how they're dealing with a hit to their Medicaid budget for the new people they've made eligible for this Medicare subsidy.

Isn't that a big part of it, the state's willingness to do this must have something to do with their willingness to enroll people in anything where they're 40 to -- I think Maine is 40 probably -- 40 percent of the cost. Isn't that kind of the elephant in the room that

makes people not -- and should we be addressing that instead of marketing?

MR. HACKBARTH: Joan, in the case of Maine, as I understood the written chapter, the net effect on the state budget is not exactly known. But because of the savings that they get on the drug side, they may come out more or less even or maybe even a little ahead overall?

DR. SOKOLOVSKY: They thought at first they might come out ahead because they thought at first that they could get everybody into the QI program. And then that would be entirely federally funded.

But it turned out it didn't work that way. In fact, everybody ended up in QMB. And then they thought it was going to cost them a lot but that it was still the right thing and it was still worth doing.

And then once it actually went into effect -- and these opinions change very rapidly. So I don't believe they actually even figured out what it would cost before they did this autoenrollment.

They're finding now that the cost is modest.

MR. HACKBARTH: So they pick up more federal dollars on the drug site; right?

DR. SOKOLOVSKY: Yes.

MR. HACKBARTH: I just wanted to make sure I understood that correctly.

DR. KANE: That's probably because they already had a state-financed pharmacy program.

MR. HACKBARTH: It's exactly because of that, yes.

DR. KANE: They wanted to get federal money in to help them, and then they hoped that they would come out ahead. But there's a bunch of states that are aren't replacing...

So isn't that kind of the first step, is how do you get the states to finance it?

MR. HACKBARTH: I was pointing this out in support of what you are saying. They had reason to believe that this wouldn't be a huge state budget hit, there would be some potentially offsetting gains. In states where that's not the case, I'm sure the state financial considerations loom large in how much effort they put into this.

DR. REISCHAUER: Of course, the conceptual question is why does the feds pay 100 percent of the

subsidy for drugs and not 100 percent of the subsidy for basic medical care?

DR. MILLER: There was just one thing I wanted to pick up. It's been said in a couple of ways but Jack also said it. This is not to dismiss any of the other considerations here.

Decidedly, simplification and the asset test, and particularly coming out of the estimation world, I always thought that those were really critical factors. And if you adjusted those things, people would estimate that people would embrace these programs because the presumption was as people understood when something was economically in their benefit and they would gravitate to them.

What I found, and Joan and Sarah have heard this about 20 times so for the rest of you who haven't heard it, what I found really interesting about Joan's work was how stark it was that people just didn't even know about it. And that the people who were doing to counseling didn't even know about it.

So in my own thinking, I started to think that that is an important factor and one I've not paid as much

attention to as I should have through the last several years.

But then Jack made his point just a moment ago, in the work that you did with NACI, and said but that's unsustainable. And so you have to kind of really continue to focus on asset tests and things like that.

I wanted to maybe just talk about that one more time before we left this because I found that quite stark, asset test, simplification, they're not even getting there. They don't even know that they have to deal with this or that it's available. The counselors don't seem to know.

But then on the other hand, I think your point is kind of taken. How do you sustain this kind of information over time to keep people bringing in? And I realize that's an unfair question. But if there's anything anybody wants to say about that, that's kind of what I'm fishing for.

DR. SOKOLOVSKY: There are some policy proposals out there that aim to deal with that. And hopefully next time that I present on this I'll bring some of those up.

DR. MILLER: I forgot. That's what I was doing. This is a tag for -- right, sorry, Joan. I missed the whole script here.

We also have this other work that Joan is working on public -- right, I knew that.

[Laughter.]

MR. EBELER: I didn't mean to convey it as an either/or. Obviously if people don't know about it, the best designed, best administered, simplest program in the world doesn't help them. But the key is that it's inter-related. I think, in particular, for the human beings involved, whether you're the worker or the beneficiary, when you send somebody into an extremely complex system, some of which is explicitly or implicitly designed to keep you away, you shouldn't be surprised that one, they don't come back. And two, their neighbors, the whole culture of going to get that changes. It's the interrelationship that I think is most critical here.

DR. REISCHAUER: Do we know anything about tipping points? What if we had 100 percent participation in a state. Is that enough for the word-of-mouth and the expectations of the potential beneficiary to just change the pattern completely? I mean, once you reach the level. As opposed to having 20 percent or 25 percent of the eligibles, which isn't a critical mass. Most of your

friends who are in that situation aren't receiving it and it would never get it to a self-sustaining kind of situation.

MR. EBELER: I don't think we know, I don't think there's hard research on that. I think there's a behavioral assumption that there is a point at which there is a cultural change. This is just something that -- but I don't know that there's evidence about that from any of his work. I think there's an assumption that that makes sense.

MR. HACKBARTH: We learn a little bit about that from the low income subsidy in the drug program where there is still not hardly full participation, but a higher rate and more intensive effort. It would be interesting to watch that and see to what degree it's self-sustaining or building over time, as opposed to the other Medicare savings programs.

Okay Joan, well done. Thank you. Look forward to hearing more about that.

Next is Medicare benefit design and cost sharing.

DR. SCHMIDT: Good afternoon.

This afternoon we're going to begin a discussion about fee-for-service benefit design that will continue next month and then into next spring.

The Commission spends a lot of time discussing Medicare's payment systems for providers and their incentives and we've given relatively less attention to the incentives and the implications for financial liability in the cost sharing requirements that Medicare beneficiaries face.

The Commission took a look at fee-for-service benefit decided in 2002, the June report. Much of that analysis was completed within the context of figuring out how to include a comprehensive drug benefit while reconfiguring Part A and Part B cost sharing. Today policymakers may want to revisit the issue and use benefit design as a means of going after other policy goals that they want to achieve such as encouraging higher quality care or more efficient use of resources.

I mentioned that this would be at least a year long project and discussion on our part. This month we'll talk about some of the problems that researchers have identified in fee-for-service Medicare's benefit design and

the supplemental coverage that most beneficiaries use. Then we'll look at what may happen under some illustrative cases that address the problems.

Next month we'll have an expert panel on value-based insurance design. This is an approach to benefit design that some employers are using to encourage individuals with certain chronic conditions to adhere to their medical therapies where there is stronger evidence that doing so is an effective thing to do.

Benefit design can also be used to encourage beneficiaries to seek care from preferred providers, where preferred status could be based on measures of quality and resource use or preferred in the sense of other policy goals such as encouraging use of primary care.

After October, we'll return to the topic in the spring and our aim is to include a chapter on benefit design in the June 2008 report.

Analysts have been describing the limitations of Medicare's benefit design for a long time. Some of the key criticisms include the fact there's no cap on beneficiaries' cost sharing liability. It could reach very high levels under the fee-for-service benefit.

Medicare's cost sharing requirements vary across services. For example, beneficiaries are liable for 20 percent coinsurance for most outpatient services like physician visits. The cost sharing is 50 percent for outpatient mental health visits and as much as 42 percent for some services in hospital outpatient departments.

At the same time beneficiaries not liable for any cost sharing for laboratory services and home health visits. Some analysts believe that fee-for-service Medicare's benefit is out of date. As an example, it uses separate deductibles for Part A and Part B services, when most commercial insurers use one combined adoptable. The lack of catastrophic protection, uncertainty about how much cost sharing a beneficiary will owe, an aversion to risk, and general worry about the paperwork that might come with provider billings are all factors that create very strong incentives for Medicare beneficiaries to get supplemental coverage, and most of them do.

Only about 10 percent of beneficiaries have coverage through fee-for-service Medicare alone. In 2004 about 13 percent of beneficiaries were in managed care plans. Here managed care means both MedicareAdvantage plus

smaller numbers of other types of private plans and demonstrations. This number is a bit higher today.

Employer-sponsored retiree coverage and individually purchased Medigap policies are the source of supplemental coverage for most beneficiaries. These policies vary in their structure but often provide coverage of Medicare's cost sharing requirements from the patient's first dollar of covered spending.

Another 17 percent of beneficiaries are dually eligible for Medicaid benefits. Medicaid typically relieves the beneficiary of all or much of Medicare's premiums and cost sharing liability.

One point that analysts raise is that since supplemental policies cover the beneficiary's out-of-pocket liability, they can also reduce the beneficiary's price sensitivity. So while it may be good that supplemental policies provide some catastrophic protection, they can also lead beneficiaries to seek more care or higher priced care than they would if they had to pay for the full cost.

In turn, analysts believe that this leads to higher Medicare spending, although there is some dispute about how much higher.

An important thing to bear in mind when thinking about potential changes to Medicare's benefit design is that spending for Medicare covered services is highly concentrated. If you look at the bar on the left-hand side of the slide, it tells you about the distribution of beneficiaries' out-of-pocket spending for Medicare covered services. By out-of-pocket spending, I mean their cost sharing liability, not including their premiums for Medicare or their premiums for supplemental coverage. Those show up in the next -- well, the ones for supplemental coverage anyway -- show up in the next bar over, as part of the third-party payer spending.

But looking again at the left-hand side, the dark orange part of the first bar shows at the most costly 25 percent of Medicare beneficiaries pay for about two-thirds of all out-of-pocket spending. Those same beneficiaries account for even greater shares of spending for Medicare covered services by third-party payers and Medicare program spending.

So given our discussion about problems with the sustainability of Medicare's financing, it seems that policymakers will want to hold Medicare program spending

constant rather than adding to it. So the general implication of this concentration in spending is that in order to keep budget neutral while lightning the financial burden for the relatively small group of beneficiaries that have high out-of-pocket spending, policymakers would need to spread the burden around and a larger number of beneficiaries who have relatively low out-of-pocket spending today would probably have to pay more.

I'm going to walk you through some illustrative examples that show some of the key levers that analysts talk about when they consider changes to fee-for-service benefits. These are not specific policy proposals that the Commission is considering, just illustrative. Here I should add an important caveat, that we're also not getting into some very important issues, such as the effects that these illustrative cases might have on access to care.

So remember that the ground rules here are that these need to be budget neutral to expected levels of program spending.

The Actuarial Research Corporation did some simulations for us to try and get a sense of the distributional effects of different benefit designs. They

used a beneficiary level simulation model that was based on data from the Medical Expenditure Panel Survey data, 2004 data. It was also set to match the levels of use in spending from the 2007 Trustees report.

One thing to warn you about is that the stimulations of the distributional effects on out-of-pocket spending can be counterintuitive. I'll walk you through an example in just a minute of what I mean. The reason for this relates to supplemental coverage. As you change Medicare's cost sharing requirements, effects on out-of-pocket spending depend on whether a beneficiary has supplemental coverage and how that supplemental coverage wraps around the new benefit design.

Lastly, let me note that this analysis does not include Part D for two reasons. First, we do not yet have Part D data on spending. Second, if we could, it would be pretty complicated to figure out how to coordinate cost sharing requirements administered by stand-alone drug plans with those for Part A and Part B services in traditional Medicare.

DR. MILLER: Rachel, so these are just illustrative?

DR. SCHMIDT: Yes, let me say that once again. These are just illustrative, Mark.

[Laughter.]

DR. MILLER: Thank you. For the public, to be absolutely clear on that.

And then also, on the counterintuitive point. Your basic point there is that you might change cost sharing and increase cost sharing, but you might not see the effect that you would expect from that because of a beneficiary is insured against it.

DR. SCHMIDT: Thank you for the segue to my next slide.

DR. MILLER: No problem.

[Laughter.]

DR. SCHMIDT: Let's walk through an example of how supplemental coverage can interact with a policy proposal.

Let's pretend that policymakers decide that they want to raise the Part B deductible for some reason, from the $131 it is today to something higher. One would naturally think that all Medicare beneficiaries would pay more out-of-pocket with this change. However, the policy

might really only affect out-of-pocket spending for those beneficiaries who don't have any supplemental coverage, and those are shown in the top row in this table.

So in this simple look at out-of-pocket spending, a dual eligible, for example, would probably see no change with a higher deductible because Medicaid would likely continue to pay for all of the higher deductible. Similarly, lots of Medigap and retiree policies also cover the Part B deductible. So those beneficiaries might not see a change in their out-of-pocket spending. And here let me remind you --

DR. REISCHAUER: But their premiums would all go up.

DR. SCHMIDT: Yes. Next point. Thank you. I'll let us you guys deliver this next time.

So here when I say out-of-pocket, I'm only referring to the cost sharing requirements. But, as Bob just said, you should expect that Medigap and retiree policies would probably have higher premiums under this policy change.

MR. HACKBARTH: I'm going to sit between them.

DR. SCHMIDT: Thank you, Glenn.

[Laughter.]

DR. SCHMIDT: In the following couple of slides, I'm going to describe cases using this relatively simple approach that just looks at out-of-pocket spending. Then for the last two cases we'll talk about the effects of adding in the changes to supplemental premiums.

Here's the first illustrative case. We're going to look at the approach that commercial insurers use today with one combined deductible for both inpatient and outpatient services. Remember that for these illustrations we stay budget neutral. So the question is at what level would you have to set this combined deductible for Part A and Part B services to stay budget neutral? ARC estimates at all beneficiaries who use A or B services would need to pay the first $520 of their Medicare covered service in order to break even with current law spending.

Today each year about 20 percent of fee-for-service beneficiaries have a hospitalization, which for 2007 means that they're liable for a $992 Part A deductible. And many more beneficiaries, in fact most, use Part B services and they're liable for the $131 Part B

deductible. But many of those people have relatively lower overall spending.

For a combined deductible, you might think that something on the order of 20 percent of beneficiaries would have the lower out-of-pocket spending. As it turns out, if supplemental policies continue to cover this combined deductible in the same manner that they cover the separate once today, only about 7 percent of beneficiaries would have lower out-of-pocket spending. These would primarily be people who have a hospitalization and either only had Medicare or had a supplemental coverage that didn't cover the Part A deductible.

In other words, the wrap around coverage that many beneficiaries have through Medicaid, Medigaps and former employers shields them today from paying the deductibles directly and this could happen under a combined deductible as well.

In this scenario, ARC estimated that 30 percent would have higher out-of-pocket spending. If you remember that we have not taken into account changes in supplemental premiums.

So as a second illustration, let's keep the same cost sharing provisions that we have today but add a catastrophic cap. At the same time, we're trying to keep this budget neutral so we'll need some way to pay for the added benefit costs of that cap. In this case, we'll do this by charging everyone who uses Part A or Part B services a higher combined deductible.

In this slide, I've got a case we just went over, no cap on out-of-pocket spending with a $520 combined deductible on the first row. And now, if we add a catastrophic cap but at a fairly high-level, so $7,500 shown on the second row, it would still require all people who use A or B services to pay a combined deductible of $705. So even though relatively few people have that high a level of spending and would reach $7,500 in out-of-pocket spending, it would be a sufficient level of benefit costs added to the program that we'd have to raise the combined deductible up a bit.

Under the second scenario about 8 percent of beneficiaries would have lower out-of-pocket spending covered by the cap and 34 percent would have higher out-of-pocket spending. Again, we haven't taken supplemental

premiums into account here, just their out-of-pocket spending for cost sharing.

So if policymakers wanted to set a lower out-of-pocket cap, it would require an even higher combined deductible. For example, if you look at the bottom row in this table, all users of A or B services would have to pay the first $1,295 of their spending in order to pay for a catastrophic cap set at $3,000.

Now I'm going to get into the more complicated approach that takes into account changes in out-of-pocket spending plus changes to premiums that beneficiaries pay for their supplemental coverage. So one policy lever that researchers talk about is limiting the degree to which supplemental policies may cover Medicare's cost sharing. This example is very narrow and it would only restrict insurers from covering the Part A and Part B deductibles that we see today. So insurers could still cover other parts of Medicare's cost sharing. Medicaid would be allowed to continue covering the deductibles but Medigap policies and employer sponsored health plans could not. Those beneficiaries would have to start paying the deductibles themselves.

This example may not reduce federal program spending by much. ARC estimates that it would be less than 1 percent lower than current level of Medicare spending. So if policymakers wanted to reduce program spending through limits on supplemental coverage, they would need to make tighter restrictions than this on what Medigap and employer-sponsored coverage plans could cover.

On the left you see an estimate of how beneficiaries out-of-pocket spending would change under the policy. Most people would have to pay more out-of-pocket because they would have to pay for the deductibles themselves. However, on the right-hand side, we see the distributional effects of the policy when you consider both out-of-pocket spending and the changes in premiums for supplemental coverage. Nearly half of fee-for-service beneficiaries would have lower spending for the two.

Note that these are crude estimates that use very simplified assumptions about Medigap and employer-sponsored premiums. Nevertheless it's important to note that these combined effects can look very different from just looking at out-of-pocket alone.

As a final case, we combine many of the changes we've already looked at. There's a combined deductible, a catastrophic cap, limits on what supplemental coverage could cover. In addition, we charge a uniform 20 percent coinsurance on all types of Part A and Part B services. So now beneficiaries with a hospitalization would be responsible for a much higher amount of cost sharing, 20 percent rather than the $992 deductible, and people who use services that don't now have cost sharing like laboratory tests and home health visits would have to begin paying 20 percent.

On the other hand, beneficiaries who now pay 50 percent of allowable costs for outpatient mental health and over 40 percent for some types of services at hospital outpatient departments would see some relief.

The illustration would also cap beneficiaries out-of-pocket liability at $3,100, which is the level of a cap that CMS has told MA plans that they should consider in 2007 if they want to avoid closer scrutiny of their cost sharing requirements.

This illustrative scenario would also prohibit Medigaps and retiree plans from covering the combined deductible.

So this illustration has a lot of moving parts to it. It would lead to some higher program costs from adding the catastrophic cap, but lower program cost to the degree that patients who use Part A and other types of services begin paying more. The end result though is that in order to break even with expected levels of Medicare program spending, all beneficiaries who use A or B services would have to pay for the first $445 of their care.

For the distributional effects on beneficiaries I'm just showing you what they look like for the combination of out-of-pocket plus our crude estimates of how this would change Medigap and retiree premiums. About 39 percent of fee-for-service beneficiaries would have lower combined costs and 42 percent would have higher costs.

Here are some points I hope you take away from this analysis. We have described some of the important limitations in fee-for-service Medicare's benefit design, the lack of catastrophic coverage, maybe an out of date

design, the unevenness of its cost sharing and the incentives for supplemental coverage. We talked about the fact that spending for Medicare covered services is highly concentrated and options for changing the benefit design really need to include anticipated effects of supplemental coverage.

Lastly, as Evan's presentation from this morning showed, policymakers have some big questions ahead related to Medicare's long-term financing. Under these circumstances, it's likely that if policymakers decide to make changes to the fee-for-service benefit design, those changes will need to be budget neutral. So it's important to understand that in order to keep things budget neutral and lighten the cost-sharing liability for those who have got high out-of-pocket spending today, a sizable share of other beneficiaries would have to begin paying more in cost sharing.

Some analysts have suggested that one way to free up resources for changes to the benefit design is to redesigned Medigap policies and retiree coverage. In other words, to the extent that supplemental coverage leads beneficiaries to have higher Medicare spending, asking

those with very complete wraparound coverage to pay more cost sharing at the point of service may reduce the higher spending somewhat. And that, in turn, could potentially free up resources to improve the fee-for-service benefit design.

As we saw with the illustrative case number three, policymakers would probably need to do more than just limit supplemental policies from covering the Medicare deductibles in order to finance something.

I would appreciate getting your feedback on this as well as suggestions for other scenarios you'd like us to look at.

MR. HACKBARTH: Just one observation on that last illustrative case. Of course, another feature of that policy could be added coverage for low income beneficiaries, in keeping with the previous discussion. So if you're going to have a system that increases cost sharing, limits the ability to fill it in with supplemental coverage, you could refocus your efforts on the low income support and provide maximum protection for those people.

DR. BORMAN: Just a couple of things that I was struck by. Very nice presentation, Rachel. I think I

followed it and it's pretty complex for a plain Jane general surgeon.

I am somewhat reminded in all the emphasis on illustrative and so forth another exercise that we went through in looking at a similarly arcane thing, the practice expense. I think it is helpful to go through these exercises to kind of see how some of the things we toss around play out. And you've done a really nice job of that.

Two things that I was particularly struck by. One is you've made the very fine point, and we've heard it before, about the concentration of utilization in very definable groups. Nick and Jay and Arnie have talked about that over and over too, I think, and John. I think this links up to our notion about trying to target the high cost, high volume, manipulatable things where we think all this other stuff, comparative effectiveness, coordinated care and so forth, can make a difference. This is kind of like added support to that and hopefully we can continue to make those linkages across the big concepts. I think this offers that opportunity.

I would also bring up the thing that I'm struck by is we're not going to answer a lot of things by these fairly blunt big changes. I think that's a big part of what you've shown us. We are going to need to consider some targeted tiered intervention. And I realize the tiered benefit is a bad connotation thing.

But just for example, particularly as our comparative effectiveness information becomes better, there are going to be some pieces that are preference sensitive for the patient, not just for the provider. We've talked about preference sensitive services being from providers. But there are certainly some of those on the patient side. For example, when we were discussing different models of walkers, there will be some that will be better at helping someone walk and there will be some that look nicer and have better bells and whistles. If you want to have the one that has better bells and whistles and comes in more colors, then you should have to put more toward that.

For example, there are increasing data coming out that repairing an abdominal aortic aneurysm by open surgery and endovascular is going to come out to have about the same complication rate when you look at the whole package

of time. So if somebody says but gee, I don't want that incision, I don't want to do it as a hospitalization or whatever, then maybe they're going to have to put something toward that.

So to the extent that there's any way to start teasing into how could we develop this in a targeted way, that is do we want to look at limiting deductibles and coinsurance for basic health services and then look at different methods for discretionary things?

MR. HACKBARTH: What's the term that's been coined for that sort of design? I always forget it.

DR. SCHMIDT: Value-based insurance design.

MR. HACKBARTH: Mike Chernew at Harvard and Jamie Robinson --

DR. SCHMIDT: I would say stay tuned for next month because we'll have an expert panel on just that topic. DR. WOLTER: I certainly don't consider myself an expert on benefit design but I'm sort of intrigued with a concert I have been reading and hearing about which has to do with predictive modeling of a population of beneficiaries where you identify as subgroup that's much more likely to incur a high expense in the future year.

And then instead of the theory that they would have less first dollar coverage, you might target a benefit package that would provide more first dollar coverage around chronic disease management with the idea that you might actually save a lot of money by focusing on that subgroup. I think that's an intriguing concept. I don't know what research is out there about it. But certainly in the Medicare population it's something we should consider or at least follow.

DR. SCHMIDT: In fact, that's actually much closer to the definition of value-based insurance design as the literature is starting to evolve. I think you're going to hear quite a bit about it next month.

DR. KANE: Could you go to slide five, the concentration slide.

Cost sharing as not going to hit the orange bar on the left; right? Because they're going to blow right over their catastrophic -- let me just finish my thought.

Did any of the estimates include the behavioral response to cost sharing?

DR. SCHMIDT: Yes.

DR. KANE: To reflect the reduction in volume that's supposed to happen.

DR. SCHMIDT: Yes.

DR. KANE: So to go to this slide again, the 25 percent who spend --

DR. SCHMIDT: This is current law though. This isn't under a policy option.

DR. KANE: Right. But I'm just trying to get at where does cost sharing -- where is it going to have its big impact? For the 25 percent, how much of an impact is it going to have as opposed to the 50 percent who don't spend anything at all are going to be cost sharing more. But they're only spending 4 percent of the program expenditures. So I guess I'm pretty get a sense of who are we trying to impact here? And does cost sharing, is that the best way to impact the 25 percent with the high costs? Or is it really mostly going to impact the 50 percent with the 4 percent expenditure?

DR. SCANLON: It's the least costly half. It's not people spending zero.

DR. KANE: I know they're spending something. But we're talking -- the 50 percent who might have to pay

more are only incurring 4 percent of program expenditures, whatever that number. I'm interpreting that. See Medicare program expenditure, the white bar, that's about 4 or 5 percent of total program expenditure. And see the white bar on the far left, out of pocket.

DR. SCHMIDT: I don't think that these options were designed necessary to reduce program spending. In fact, illustrative cases we looked at were designed to stay budget neutral. But it was to deal with what is perceived as an inadequacy in the benefit design, namely the lack of catastrophic protection.

DR. KANE: That's part of it. But aren't you also saying there's moral hazard to having Medigap coverage?

DR. SCHMIDT: Certainly.

DR. KANE: Where is the moral impact on that? Whose behavior are you trying to impact with increased deductible cost sharing? And where does it show up? Because if most of the spending is by the high cost people, how does cost sharing effect -- because don't they blow through their real incentives pretty early on in their illness?

DR. SCHMIDT: Maybe that's a segue to what I know is John's comment.

DR. KANE: I guess I'm trying to get a sense of whose behavior is cost sharing -- do we really think cost sharing is going to -- and where on those -- is it really going to affect the big bar of the really expensive people or not?

MR. HACKBARTH: John is the only one with the appropriate circulation for this questions.

MR. BERTKO: I have talked to Rachel ahead on this particular thing. And partly, Nancy, to answer your question but to make a general comment, there are some inconsistencies between the modeling reported here and I think, Even, what you had in your part about what is the induced demand for Medigap.

So let me throw a few numbers around that come out of things we've talked about today. 26 percent of people, according to Rachel's graph, have a combination of either Medigap or Medigap plus employer. Roughly that translates to $100 billion in spending out of the $400 plus billion in the whole of the Medicare budget. And 20 to 25

percent of that is easily $20 billion to $25 billion of induced demand, as identified by earlier studies.

The amount that Rachel's modeling from ARC comes up with is merely $2 billion. That is a huge difference.

Now part of this is due to the underlying assumption that there is only an effect on deductibles, as opposed to the coinsurance later on. But still the difference is between Danny DeVito and Shaquille O'Neal, to use a modest metaphor.

Now let me continue on with the directions here. As you look at changes in cost sharing, in my experience, the biggest difference comes from zero to something. All these Medigap people, not talking about ESI, are going from effectively zero Part B cost sharing to something. I agree with your comment that they off-line when you start going over the top.

But something like 93 percent of those people are going to have a Part B type of thing either at some point, and maybe 85 percent of them before they hit a Part A deductible. So a huge, huge proportion of these people are going to have to start thinking about spending some amount

of money, whether it's a deductible and coinsurance or a copay under some different system.

My gut feeling here, without having recalculated this stuff, is it's much bigger than $2 billion and it's smaller than $25 billion. But it's a big amount of money. The consequence being, I think, I'm going to ask Rachel to rethink that a little bit and maybe ask some questions on the induced demand behavioral adjustment that the contractor used on this.

I would tell you with lots of experience mainly in a managed care system, the effect is much bigger.

DR. KANE: Just to continue on, the third bar, Medicare program spending. There is an orange, a yellow, and a white part of that bar. Which part of that bar is most likely to be most vulnerable to this kind of cost sharing?

MR. BERTKO: Orange and yellow because every single person in the orange and yellow is going to walk in there, other than somebody who falls into the hospital on the first day of the year, and say ah, do I want to pay $50 for this physician visit two or three times?

DR. KANE: But they're sick.

MR. BERTKO: They're sick but not all of them are sick, not all of them do -- I mean, there is some amount of going to the doctor for social reasons and other things.

DR. KANE: But I would think that would be the white bar more than the orange bar.

MR. BERTKO: No. It's the orange and yellow.

DR. KANE: You think of that 26 percent a lot of them are really healthy people, just socializing at the doctor's office?

MR. BERTKO: It doesn't matter whether they're healthy or not. They're going to go, they're going to think about do I need a doctor visit in the month of January? Or does the December visit take care of me?

Do I have a pharmacy prescription that takes me a couple of months with refills or do I need to visit the doctor again?

DR. KANE: So I guess I'd like to know are the mostly costly 25 percent really sick or are they just socializing at the -- some of them are. How many of them are just socializing at the doctor's office and how many of them are really sick? I guess that's the part I don't understand in terms of behavioral --

MR. HACKBARTH: Just for the record, so the audience doesn't get a misperception, there is care between socializing with the doctor. For example, self-limiting conditions that people are sick but they're going to go away even if they don't go to the doctor. It may take a few days longer or whatever. So it doesn't all fall into those two categories.

DR. MILLER: I also think, just strip away the actual dollars for a minute. Nancy, your point is that as we think through the benefit design here and the incidents of what the increased cost sharing is, there is some population who's going to blow right through all of that because they are sick. That's your fundamental point. Whether it's quantified between two and 25, your point is we need to be thinking about that. I think that's what you're driving at.

MR. HACKBARTH: Ultimately, it's a question that you've got to work through the numbers in great detail to understand the answer. And that's probably beyond what we can do in this meeting.

MR. EBELER: I'm tempted to ask, Mark, whether these are proposals or illustrative examples because you

haven't had a chance to comment on that lately. But instead, a boring data question.

You mentioned, I think, that the database on which these analyses are based are pre-implementation of MMA, 2004. One, I think it means we need to be cautious. But two, when will we have an analytic set of data that includes the first year of implementation of the drug benefit?

DR. SCHMIDT: A lot of these simulation models that allow us to do these kinds of exercises are based on either the MEPS data or the Medicare Current Beneficiary Survey. Generally you need a two to three year lag in order to go through their reconciliation process of collecting the survey data and sifting through and making sure they're reliable. So it could be --

MR. HACKBARTH: Not during your tenure as a Medicare commissioner.

MR. EBELER: It's a very important analytic problem as we change something that's already been changed. We just really need to figure out how to deal with that.

MR. BERTKO: Can I jump in? Rachel and I have been talking. There is another source of data which could

become available on Part D stuff in relatively short order. The question there is what's the accessibility of it? And how would MedPAC use it?

DR. REISCHAUER: Not to bring us back to reality but revealed preferences suggest that the American Medicare participants want to be over insured and they are willing to pay a premium to be over insured, namely the loading factor that is added on to Medigap policies.

If we were following revealed preferences, we would say let's have first dollar coverage for everything. Forget about all of this. And so there's a real question on if you go down some of these lines are you talking about something that has a shred of political viability? That's number one.

Number two, we talk about induced demand as if the demand that is being induced by this is all unnecessary services, low value services, whatever. And we don't know what it is. It will differ for different people. It's a mixture. There will be probably some very needed services that are uninduced by some of these changes.

The question, of course, is who are we talking about. And what are we talking about when we are reducing the induced?

When we go to putting more stringent limits or transforming the nature of Medigap, we're also making some other changes here. Introduction of a catastrophic cap would lower premiums. Raising deductibles or coinsurance and saying you can't cover them would increase premiums for Medigap and reduce the number of people who sign up for Medigap. We're talking about probably increases in bad debt as a result of that, because some people just won't be able to pay their section.

That translates into another issue, which is access. So you're a doctor and a third of your Medicare patients don't pay their coinsurance. How willing are you going to be to take in more of these patients?

So there's a lot of moving parts here that we want to consider if we go beyond the illustrative models that have no policy relevance.

MR. HACKBARTH: Two thoughts on that. Clearly, you're right about the steep slope of the political hill that you would have to climb if it involves limiting, for

example, the ability of beneficiaries to buy supplemental coverage.

Having said that, I also remember you saying at various points in the past -- like the other day -- that --

DR. REISCHAUER: Consistency is the hobgoblin of small minds.

MR. HACKBARTH: That we have no shot whatsoever -- and I'm overstating what you said -- but it's going to be very difficult to alter these cost trends if the patients continue to think this is free. Everything is directed at the providers and they have no involvement.

So for that reason John and others have said let's think about options that at least try to bring beneficiaries into the game of trying to change the pattern.

But with that said, I have no illusions about how easy this is politically.

One other point. On the question of what kind of care goes away in the face of cost sharing, we have evidence. Not real recent evidence, but I think it's still probably valid, from the RAND health insurance experiment where this was studied it meticulously.

The answer was that the care that goes away and is reduced in the face of significant cost sharing is a mixture of appropriate and inappropriate care. So that at the end of the day the proportion of appropriate and inappropriate care is roughly the same for the patients that had complete coverage versus the patients that had the high deductible.

Let me just finish, then you can jump on me.

An important caveat on that is that that did not involve the Medicare population. And so the responses could be different.

The other point is that so far as they could detect with their measures of health status, there was no reduction in the health status of the patients that had the high cost sharing. Even though they were losing some appropriate care, their health status did not decline at the end of the day. The caveat there was that there was a slight difference and decline for low-income patients.

So we know a fair amount about how people respond to cost sharing.

Now you can go.

DR. REISCHAUER: I'm going to fight RAND with RAND and move forward two decades, if you don't mind, to more relevant data, which is the study that was done on cost sharing in drugs. It showed very small increases in copayments caused humongous reductions in necessary pharmaceutical application.

MR. HACKBARTH: And I think that's a very important point. I don't think it's necessarily inconsistent with the earlier findings of the RAND health insurance experiment. But certainly there is evidence, and growing evidence that employers and others are acting on, that high cost sharing for certain kinds of services can backfire and lead to higher costs and real problems. I agree with that, Bob.

DR. CASTELLANOS: I think we have a model today with cataract lenses in the Medicare age group. We're doing that now, with cost sharing today. So I think that model, Rachel, is available right now. We don't have to worry about what RAND did and what they didn't do. We have an ongoing model right now with cataract lenses implant, where Medicare pays a certain amount of money and if you

want a super duper or special lens, you pay the difference. I think that model may have be of help to us.

DR. CROSSON: Could we turn to the non-policy non-proposal illustration on page 11?

DR. MILLER: Thanks, Jay.

DR. CROSSON: I had two things. One has already been covered because I had the same instinct, I think, as John that going to the combined deductible, which would have the effect of increasing the Part B experience, would likely have a significant impact on utilization. Because I think it's the downstream impact of those putatively discretionary visits and the cost implications of those that are affected for good or for bad.

But the question I had was sort of along the lines of the politics of this. Because I kept looking for a pie chart, as we went through this, that had roughly equal winners and losers. And this one seems to meet that test, compared with some of the other ones.

But I wondered whether, in fact, you've looked at sort of the distribution curve of the winners and losers in terms of do we have a lot of -- in terms of lower or higher -- do we have a lot of people in there who have slightly

higher but we have people who have dramatically lower experiences? In other words, what would the distribution curve for the lower and higher people look like in this pie chart compared with the situation as it is right now? The intensity of the experience for the winners and losers or the lowers and highers.

DR. SCHMIDT: We tried to get that at that a little bit with a change of $50 or less category but I take your point. I don't have the answer to your question off the top of my head but I can certainly get such a distribution.

DR. CROSSON: One would imagine the answer to that might drive the intensity of the politics on both sides of that.

DR. MILSTEIN: Rachel didn't say this but at least I would conclude from Rachel's presentation that current Medicare cost sharing is, first of all, Byzantine. And secondly, unaligned with any coherent concept of either fairness or motivating high value choices. Every time somebody in my family asks me to explain it to them, I tell them I can't. That's not a good comment.

In that vein, at a minimum, I think some kind of simplification would be in order. For reasons I don't want to take the time to go into, I would favor some kind of a standard percentage coinsurance and get rid of the deductibles. It causes confusion on the doctor and the patient side as to where they stand. I just think it would be simpler, at a minimum, if we just had a standard coinsurance equally applied across the board.

But I think the most important point for me here is in sync with our earlier discussion that we kind of stay focused and keep our eye on what I believe is a relatively shared vision of the prize here in any change we make in the Medicare program, which goes something like this: how do we get quicker movement toward more health and lower Medicare spending increases? That's the prize.

In order to do that, with respect to beneficiary cost sharing, we need to use them to begin to create incentives for beneficiaries to select higher value choices. If we think about what higher value choices are on the list, I think my view is there are three. I'll maybe lay them out in -- I realize this is an opinion -- maybe in ascending order of political difficulty and then

maybe people who know more about this can confirm or disconfirm the sequence.

The first would be to lower cost sharing if beneficiaries pick what we've referred to as accountable care organizations that have taken on some significant responsibility for improving quality and lowering total Medicare spending. That's number one.

Next in order of political feasibility might be to lower cost sharing for beneficiaries who select treatment options that are -- I guess I shouldn't use the word more cost-effective, but have error value, which is code for more cost effective way when there are more than two pathways to an equally good health outcome.

And then third, and probably I put this third in order of political feasibility, is lower cost sharing for beneficiaries who are not using physicians who are clear outliers with respect to resource use and quality. I think that GAO's word for them in their May report recommending that we begin to identify outliers physicians was outlier physicians. You could lower cost sharing for beneficiaries who do not elect to use physicians who have been identified by CMS as outliers.

I understand that's politically difficult. That's why I listed it third.

I think most important is sometimes we reflect back on our work and say why aren't we getting to where we want go? Partly because we forget to dovetail all of the tweaks we make with respect to the common goal of improving affordability -- lowering Medicare and trying to improve quality.

DR. DEAN: I think Arnie just pretty much made the same point that I was going to make, that I don't think any of this is really interpretable until we really decide what we're trying to accomplish. And until we can really get good data -- I mean, there may well be some services we ought to pay people to come in to get, whereas there's some we should have a sky high deductible. Until we have good comparative effectiveness data and some of that, and we really know the value of the various services, these numbers don't really help very much I don't think.

MR. HACKBARTH: As Rachel indicated, the next session is going to be a much more strategic way of thinking about how you might structure the cost sharing, in an illustrative sort of way.

[Laughter.]

DR. STUART: I have two points. The first is that we're not the Congressional Budget Office and so we're not responsible for just coming up with a point estimate. It turns out that the assumptions that underlie these estimates are, in some cases, pretty questionable. It would be really useful -- and it's nothing against the Actuarial Research Corporation -- but to have these things explicit so that we can look at them. And then also to test the sensitivity of these results to those assumptions. My guess is that they're going to be pretty sensitive.

The second point is, I will ask you to go back to that slide that has the big orange bar. The reason that I want you to do that is that when we do these estimates we implicitly assume that people are born on January 1st and then they do a mind dump on December 31st, and then they start fresh on the next January 1st. It turns out people don't behave that way. What their background is in terms of spending is really important in terms of predictions about what they're going to spend in the future.

Now this assumes that everybody is basically the same year after year. The fact is that's not at all true.

Those people that are really high spenders in one year tend to be reasonably high in the next year and the previous year. But the really high spenders are not. That's very impersistent.

So having some sense of how people behave over a time horizon, particularly if we're interested in some longer-term estimates of what the impact of cost sharing is going to be, I think is a really high priority. I just have not seen that in the literature.

DR. SCHMIDT: Actually, we did some work on that a few years ago for a disease management chapter and there's some pretty interesting charts we can pull out from that because I don't think the story has changed a lot since we did that work.

On your point about the sensitivity of the simulation models, yes, that's quite valid. In ARC's case, they been very up front about what their assumptions are with me and we can certainly test the sensitivity of those.

MR. HACKBARTH: Okay, thank you, Rachel.

Next up is improvement in the hospital outpatient prospective payment system.

DR. ZABINSKI: Today we're going to discuss some initial work we've done on refining the outpatient PPS and briefly discuss our longer range plans on this issue.

To start, we have some preliminary results from some data analysis that reveals systematic payment inaccuracies do exist in the outpatient PPS. The systematic differences between payments and cost in a prospective payment system can cause some problems. For example, it can cause providers decisions over which services to furnish to be affected by financial criteria rather than clinical. Also, it can create payment inequities among providers.

Further preliminary results reveal two sources of payment inaccuracies among providers in the outpatient PPS. First, we found that high cost complex services tend to have higher profit margins than lower cost more basic services. This creates an inequity in that it favors hospitals that provide relatively high shares of complex services. Also it creates financial incentives for providers to furnish more complex services such as ICD implants or MRIs and fewer basic services such as allergy tests.

Our data analysis also reveals economies of scale in outpatient departments in that cost per services tend to decline as hospital volume increases. At the same time though, the outpatient PPS does not adjust hospital outpatient payments for their outpatient volume. This also creates an inequity in that isolated low volume hospitals are at a disadvantage. These hospitals cannot take advantage of economies of scale simply because of their remote location.

This is an important issue in isolated areas because in remote areas these hospitals are often important to maintaining beneficiaries' access to care.

For the rest of our discussion we'll focus on these two sources of payment inaccuracy. Turning first to the higher profitability of complex services, we have identified three possible reasons why we have estimated higher profit margins among complex services. The first of these possible reasons is a factor called charge compression that may have biased our profitability estimate of individual services. Charge compression is a rather complicated issue and I'll talk about that in more detail over the next two slides. In particular, I'll define it.

A second reason we may have estimated high profitability among complex services is that it appears that new technology services are quite profitable.

And then a third and final reason is that CMS bases payment rates for most services on costs from two-year old claims data. Over the next few slides I'll discuss these three possible reasons in more detail.

First, let's turn to the issue of charge compression. As I said, charge compression is a complex issue. Before I talk about why it may be one reason why we estimate high profitability among complex services, I want to basically just define what it is.

To start, consider that the basis for setting payment rates in the outpatient PPS is charges adjusted to costs using department level cost-to-charge ratios or CCRs, where the idea of a hospital department is something like a medical supplies or radiology. Now a hospital department can encompass a wide range of items, so within a department hospitals sometimes have high markups for low-cost items and low markups for high-cost items. This means that costs relative to charges, that is the cost-to-charge ratios, are lower for low-cost items and higher for high-cost items.

So applying the same department level CCR to all items within the same department can end up understating the cost of high-cost items and overstating the cost of low-cost items. That's charge compression.

We are concerned about charge compression for two reasons. First, charge compression can cause systematic payment inaccuracies. Consider first that payment rates are based on estimated service cost. These services cost, in turn, are based on estimated cost of inputs which, as I explained on the previous slide, may be overestimated or underestimated because of charge compression. So in the end, payments will inaccurately represent the true costs of hospitals to provide the service.

CMS has expressed some concern about this issue and is in the process of studying it.

The second reason that we're concerned about charge compression is that it may be biasing the profitability that we estimate for specific services and it may be one reason why we're finding higher profit margins among complex service more so than basic services. But I emphasize that charge compression is biasing the results only if the magnitude of the charge compression and the

effect that it has on cost estimates is changing over time. This is an issue we are in the process of studying right now. We will return to you with our findings in a few months.

A second reason why we may be finding higher profitability among complex services is that new technology services appear to be quite profitable. For example, in 2005 we found that 19 of 25 new tech services had profit margins above the overall average. So why might this new tech services be relatively profitable? Consider that CMS uses charges from claims to set payment rates for most services. However, new tech services are so new that CMS does not have claims data for those services. So CMS instead relies in part on external sources to set payment rates for new tech services and it's questionable whether the data from these external sources actually reflects hospitals' cost of furnishing them.

A third and final reason we may be finding higher profitability among complex services is that payment rates for most services are based on two-year-old cost data. For example, we use payment rates and costs from 2005 to estimate profit margins for our study today. However those

2005 payment rates are based on 2003 cost data. It's plausible that during this two-year window between 2003 and 2005 that hospitals costs for furnishing complex services actually declined. This may have occurred, first of all, perhaps because hospitals became more efficient at furnishing complex services or perhaps because costs of important inputs such as devices had declined during that period. That's also something we're looking into.

The next step in our analysis of relatively high profitability of complex services includes to start by determining the extent to which each of those three possible causes we have discussed actually affect the differences in profit margins between complex and basic services. Then based on what we find, we want to develop solutions to eliminate the differences in profitability between complex and basic services.

Now I'd like to turn to the other source of payment inaccuracies that I discussed earlier, that being economies of scale in hospital outpatient departments. In particular, regression analyses by MedPAC staff and CMS indicate that costs per service in OPDs declines as outpatient volume increases. But at the same time, the

outpatient PPS does not adjust payments for hospitals' outpatient service volumes.

Consequently payments relative to costs will be tend to be higher among high-volume hospitals than among low-volume hospitals, creating inequities between those two groups. In isolated areas this is important because hospitals may be unable to take advantage of the economies of scale, raising concerns over hospitals' viability in remote areas.

These inequities caused by economies of scale could be addressed with adjustments on payments to low volume hospitals. Because costs per service tends to increase as hospital volume decreases, the rate of adjustment should increase as hospital volume decreases. Finally, in the end, the magnitude of the adjustment should be such that there is no financial advantage for a hospital to increase or decrease its outpatient volume.

In addition, there should be a requirement that hospitals be a minimum distance from any other hospital furnishing outpatient services in order to receive any low volume assistance. This would help target hospitals that are low volume because they're isolated. These hospitals

are often important to maintaining beneficiaries' access to care because they are often the sole source of hospital care in an area. Also, a distance requirement would help avoid making additional payments to hospitals that are low volume because of poor clinical performance or because they are in market with excess capacity.

A final result that we've come up with so far is that because of the two sources of payment inaccuracies that we've discussed today, there has been a different experience between urban and rural hospitals in the outpatient PPS. For example, in regard to the relatively high profitability of complex services, our analysis indicates that rural hospitals have a less complex mix of services on average than their urban counterparts. So to the extent that complex services are more profitable than more basic services, this is something of a disadvantage for rural hospitals.

Secondly, in regard to economies of scale, rural hospitals are much more likely than their urban counterparts to be isolated and low volume. Consequently, rural hospitals have less opportunities to take advantage of economies of scale.

So although the systematic payment inaccuracies have a different effect on urban and rural hospitals, there has actually been little difference in the outpatient margins between these two groups throughout the history of the outpatient PPS. This is because rural hospitals have been receiving supplements to their outpatient PPS payments. However, these supplements are inefficient mechanisms because they do not directly address the underlying causes of the difference in experiences that urban and rural hospitals have had. More targeted policies would improve the process for setting the payment rates in the outpatient PPS through differences in profitability among services. And second, you would want to adjust outpatient PPS payments to account for the higher cost experienced by low volume hospitals.

So to conclude a summary of our discussion, we started that preliminary results suggest a presence of payment inaccuracies in the outpatient PPS but more analysis is needed to confirm these initial results and to develop policy solutions to reduce payment inaccuracies.

Now addressing payment adequacies is actually only part of a larger study to address issues in the

outpatient PPS. In addition, we also want to examine two avenues for increasing hospital's incentives for efficient production of services. In particular, we want to examine the extent to which we could increase packaging of ancillary services with associated independent services. Also, we want to examine the extent to which surgical procedures and other clinically related services could be bundled into a larger single payment unit.

That concludes my discussion and I seek your guidance on a direction of this work for refining the outpatient PPS.

MS. DePARLE: At the risk of complicating this even further, I guess I had a question in reading the paper about whether or we have started with the right -- started our analysis at the right level. The reason I say that is that we're talking about payment inaccuracies and the source of them. But I'm not sure we're really going back far enough to the original source of the payment inaccuracies which, unless I'm wrong, goes back to when this payment system was put together. I'm looking at Mark because you were there, too. You know why.

DR. MILLER: Is this illustrative?

MS. DePARLE: To the extent that this system was put together quickly based on historical spending in the outpatient department, which in itself is a source of some dispute as to what that exactly was, number one.

Number two, the murky relationship between the way costs are allocated between and among the inpatient and outpatient systems, both before the OPPS went into effect and now. I mean, it's an important issue. We need to be looking at it. Nick, I think, has spoken eloquently about his concerns about the adequacy of payment on the outpatient side and the trends there. I think everyone's concerned about it.

But I just wonder whether we started our analysis at the right place.

I think it's especially important now that Congress is now basing other payment systems -- imaging services for one in the DRA -- on how much imaging is paid in the outpatient department. Unclear whether those two things are -- you're buying the same thing or not. And also ASCs now, we have a new payment system where ASCs are paid a percentage of what hospitals are paid in the outpatient department.

And I have to confess, I don't know whether that's a reasonable or fair way to do it or not. I have questions about that based on what I remember about how the outpatient prospective payment system was developed.

MR. HACKBARTH: So Nancy-Ann, what I hear you saying is that in addition to there being issues potentially about how we adjust the payment for different types of services, there are also issues about the base level of the payment and whether it was properly set.

MS. DePARLE: Exactly. We seem to be looking at this several generations past at inaccuracies among hospitals and rural and urban and low volume and high volume. But I'm just wondering, do we really -- I don't think I understand whether the base payment system is right.

DR. ZABINSKI: I just want to make sure I understand the first point about going back to the base, based on historical spending in outpatient departments. Are you saying that, you know, the initial outpatient PPS the idea was as far as aggregate spending was to match what they had in the cost basis and that proceeded it? Is that

your concern, that that was sort of questionable as a starting point? Is that what you're getting at?

MS. DePARLE: Not so much that, but I think we're using words like costs as though we really know what the bundle was. The costs were allocated for the different APCs among how hospitals have been reporting that they were spending them. I don't know for a fact what that represents. Again, I said as a prelude, at the risk of making this more complicated, maybe it's just best to not pick that rock up.

DR. MILLER: I had the same question that Dan had, for starters, that I couldn't tell -- and now I think I'm clear. I couldn't tell whether you were saying in aggregate did we start from the right place? Or for any given APC did we start in the right place?

And I think one thing I would say, Dan, and I have no idea whether there is any truth in this. Whatever the metric is that you're working with is you are, even from that point, able to systematically tell whether some APCs appear to be being paid more or less fairly. And so in a sense what he's saying is -- I think -- and a way to think about this, for the people who this isn't their first

meeting, is we're going through the same exercise we did with inpatient PPS, in a sense, is looking across the various payment categories and trying to figure out whether some are systematically over and underpaid.

But even there, under PPS, we're 20 years into PPS. And the actual costs for a given service at that point is somewhat questionable. I think what we're talking about, Dan, is sort of recalibrating across the various categories. MR. HACKBARTH: Let me just push on this a little bit harder. In talking about prospective payment systems, we talk about a base rate and then adjustments to that rate for different services or for different diagnoses. Much of Dan's presentation was directed at how we adjust for the different APCs and whether we're doing that accurately or whether there's systematic bias towards certain types of services that create high profit and low profit.

He did not really address the base level of spending. And I think that's where the discussion that we often have with Nick about the outpatient margins is really a base payment issue. That's where the overhead allocation between inpatient and outpatient comes into play.

MS. DePARLE: Mark, you helped me clarify this because I really am talking about both. And frankly, perhaps I shouldn't be because other than Nick raising it, it's not like the hospitals I'm hearing are complaining about OPPS and saying that -- they were at the time that but I'm not hearing a lot of complaints about the base payment rates being inaccurate.

DR. MILLER: They will now.

[Laughter.]

MS. DePARLE: Since you asked, since this is on the agenda, I have to admit I'm unclear on it.

DR. SCANLON: Maybe since you're talking about the base this is not quite the same, but it follows somehow on Mark.

If charge compression is a reality, and I think it is a reality, then there's the question of what kind of data do we have that we're going to allow us to sort out for each one of the APCs, whether or not it's right or wrong? It seems to me that we're going to end up with some we can know are wrong in either direction. But there's going to be a group in the middle where we're actually getting too many inputs coming from the same department,

where we're dealing with the same cost-to-charge ratio. And there it's undetermined in terms of whether or not it's the right payment because we don't have independent information on the costs.

And that's a key, I think, here in terms of going from saying there's a problem to saying okay, here's a solution because you can only think about fixing part of it. DR. MILLER: And when we dealt with this and Dan, you may know this. And Jeff, I don't know if you do.

But on the inpatient side basically they used some regression techniques to try and get their best estimate of how far the compression was off, made adjustments up and down. And it's probably exactly as you say, it's really mostly in the extreme cases and in the middle probably not so much.

I'm assuming that here we're talking about the same kinds of methodologies?

DR. ZABINSKI: Yes. I don't want to talk too much about this, I might say something wrong. But charge compression is a little different animal in the outpatient PPS because the way the outpatient and the inpatient rate setting is just a little bit different. One thing about

the outpatient PPS is they use more specific hospital departments and cost centers. So in that sense charge compression is a smaller problem.

On the other hand, this is something we actually talked about Mark, at the office. In the outpatient PPS, for example you have a medical device that's 90 percent of the cost of a service. Well, if there's any charge compression problem there you're really going to mess up the cost estimate and therefore the payment rate.

So in some ways it's less of a problem, in some ways it's perhaps a bigger problem.

DR. MILLER: You did make that point. We're talking about smaller units here. The inpatient setting you have a big giant admission. In the outpatient setting you have a small visit and some stuff. Dan is just saying when your device is a big piece of that if you're charge compression -- which is often attached to devices -- then it can really throw your analysis off.

DR. WOLTER: I think philosophically trying to move to larger bundles probably does make sense and it might make the law of averages work better, et cetera, et

cetera. So I hope this work will help us move in that direction.

I think my guess is the majority of hospitals don't know what their cost per APC is very well because the way those things are bundled and the way you try to look at your cost it's kind of confusing still and it's still a new enough payment system. So maybe this will help us with that, too.

I do think hospitals are concerned about the big picture of the negative margins on the outpatient hospital side. If I'm remembering right, we've been at about minus 8 percent for a while. I have self-interest in that, I suppose.

But also as a policy issue as more and more care moves outpatient in the hospital outpatient world I think the acuity of the patients tends to be higher. Is that something we want to continue with? Especially with the deterioration of the overall Medicare margins, would we want a little more balance between how outpatient and inpatient margins look, rather than only focusing on total margin? I just think it's a policy discussion that we should have.

And then I'm so sorry to see the rural stuff back on the table again so quickly, but I have to comment on it because I think that the low volume adjuster is certainly a more elegant solution to the issue. My concern is that even with the 7.1 percent add-on and the hold harmless the data I've seen is that those rural institutions still have negative outpatient margins, even with that. And so if we remove that and then put the low volume adjuster in and leave people at negative 15 percent margins or whatever they are, I just hope we have our eyes wide open.

In fact, I hope that when we see this next we have some margin data and we have some information about where these margins sit for these rural institutions so we're not just talking philosophically about a more elegant payment system. I think that's really going to be important.

And then lastly, I don't know whether mileage by itself is a highly correlated indicator of excess capacity or it isn't. I think that's another issue that the rural people look at it very differently, I think, than sometimes we do. I hope we can have that conversation again, too.

MR. HACKBARTH: Let me go to Nick's first point that we've discussed before about the large persistent negative margin for outpatient services and whether that's indicative of some basic problem in how those rates were set.

Nick's been raising this three or four years, five years, I can't even remember for sure. Is there anything, Mark, that we can do to bring some analysis to bear on that question as part of this project?

DR. MILLER: I will say, just before I get to that, one of the reasons this is back and in this forum was really an attempt that we thought we were being responsive to you. The last time this came up you said it might be better to consider this in a broader OPD perform, low volume. I think Dan is hinting at, without the analysis being completed yet, that some of the way that the APCs break may not be advantageous to rural hospitals because of the way the profitability plays across.

And your instinct about considering some of these other things in the broader context may have been right. Of course, this is an analysis plan as opposed to the analysis. So I would just point that out.

I think the complexity of trying to address the two margins is there is a real circularity in the data. We can take that data and cut it millions of different ways but we're stuck in the context of the cost report data. The only idea that I have, which is a real expensive one is you have to go out and start doing cost studies at the hospital level where you literally go into a hospital and start unpacking books and looking through chargemasters and that type of thing.

We can contact out for that type of stuff but the dilemma we've found ourselves in when we've discussed doing them is that the cost of getting five hospitals and doing that is huge. And then you come in and you say I looked at five hospitals and people go five hospitals, you've got to be kidding me.

So that's kind of the box that I always feel in, that I can't get a big enough survey to really start to drill down and say what are the true outpatient department costs. And then if I go for such a small one I'll be blown out of the water, and rightfully, because it won't represent much of anything.

MR. HACKBARTH: On the low volume point, Nick, rest assured we heard you, your reservations about offering that as the solution to this. And it was weak medicine relative to the perceived scale of the problem. We really were talking about that.

Maybe that, in combination with a significant change in how we calculate the relative values, that those things together might have a much more dramatic impact. If, for whatever reason, we couldn't figure out how to do the APC re-jiggering or it didn't have a significant positive effect on rural hospitals I, for one, don't have any interest in offering the low volume thing again as a freestanding proposal. It would only be in the context of a package.

MR. EBELER: Just two questions. On the analysis plan, are you going to do any work about whether or not the complex high-volume new high technology procedures are medically necessary? As I was reading the chapter I was sort of wondering about whether I'm trying to figure out how to pay for something that we're really excited about getting or whether I'm trying to figure out how to pay for something that I'm worried I'm getting too much of.

DR. ZABINSKI: Being an economist I try to stay out of the clinical loop as much as I can. I guess the goal here is just to find out, get the cost relative to the payments consistent across the APCs so there's not any financial incentive to do one versus the other. It's just strictly a clinical thing.

For the new tech APCs, as far as necessity, I don't think I want to go in that direction.

MR. EBELER: It's something I think would be worth thinking about.

The second is this issue about new technology, and I don't know whether I should mention it here or when we talk about imaging. But it strikes me that when we talk about payment policy there is a difference, at least in my mind, about what we would think about in payment policy in sort of period one, as a new technology is introduced. And then what you would think about as payment policy in period two. That's probably not year two but sometime down the road after it's been diffused to a lot of providers and within those providers to a high volume.

What we don't do well is adapt in period two. The default is an update and it seems to me that a policy

where the default in period two is a much more rigorous look that reflects the presumptive lower costs of that technology at that point is what we're bad at doing.

If there are options to think about that, it would be very helpful.

DR. REISCHAUER: We've been through this in which I suggested that we use engineering curves as the default and then you come in and have to prove otherwise. That didn't get very far.

MR. HACKBARTH: We discussed it, Jack, in particular in the context of the physician payment and RVUs and new services and whether after something is introduced it's reasonable to expect that they go down the cost curve with experience.

DR. SCANLON: Part of that discussion was motivated by the fact that we don't have data, whereas in the institutional settings we do have data and we do do reweighting on an annual basis. The issue is how good are the data that we have to drive those new weights?

DR. CASTELLANOS: To make it a little bit more confusing, when we talk about economies of scale especially in the low-volume hospitals in rural areas actually,

carrying on Nancy's point, doctors in the rural area also have that low volume area. And now we're getting paid on a percentage of the OPPS scale. We get 0.68 percent of the outpatient scale.

So in the rural areas where this applies to the hospital, I would assume it's going to apply to the physician. Now I'm not a rural hospital, I'm not in a rural area. But I know it applies to physicians doing procedures in their office or in an outpatient facility. And these are paid on a basis of 68 percent of the OPPS. So I think we're opening up another little box.

The second point I have, and again Dan I'm not really into statistics. But on page eight of the material that you said, you mentioned that the correlation coefficient was only 0.2, which really indicate a very weak -- and I was wondering, we're making some decisions based on a weak assumption.

DR. ZABINSKI: Standing by itself, I'm not going to say that's not weak. I'm going to agree with you on that. But I looked at the data a number of different ways and sort of what I came up with was a number of I would say weak to moderate indicators of relatively high

profitability of these complex services. But I didn't find anything that sort of says they're not more profitable. I said we have a number of things that sort of point in that direction. I think that buttresses the argument somewhat. That's another reason I call these preliminary results.

But by itself, as I said, 0.2 is kind of weak. But you have a number of things together that help support it. So I think there's a little more behind it than having it sit by itself.

MR. HACKBARTH: Ron, can I go back to your first point about low volume for physicians? It's good to think through that. I think that's a legitimate question.

My immediate take on it, though, would be that if your unit of analysis is the individual physician, I'm not sure it's necessarily true that individual physician practice in a rural area has a lower volume than an individual physician practice in an urban area. Given the fact that there is a lower physician to population ratio in the rural area, it may be that the typical physician practice in a rural area is every bit as busy as an urban, if not more so.

DR. CASTELLANOS: I'm talking about procedures. And procedures are basically based on percentage of the population. And percentage of a population in a rural area is going to be the same for the hospital as for the physician. I don't have the data but I'm just saying that I would assume logically, say your urologist in an area in Montana is doing procedures in his office to make access of care instead of having the patient drive a hundred miles or so. He's not going to do as many as I would in a larger population. And he's getting paid on the same basis as the hospital now, a percentage of the OPPS.

So I would assume, and I don't have the data to say that, but a person in a very rural area on a small population -- and God bless, I'm glad he's out there -- he shouldn't be penalized if we're going to subsidize -- I hate to use that word -- for the hospital, I think we have to think of that physician also.

DR. REISCHAUER: Even if you're right, what it suggests is that all physicians don't have economies of scale. Just by definition they're small operations here. So you apply some low volume adjustment to all of them.

DR. CASTELLANOS: But it's going to cost that physician more money to do one or two procedures as it costs me to do, on an average say I do 10 procedures per day. It's going to cost him a lot more to do each individual procedure than I do.

DR. SCANLON: We've been talking about supply induced demand in many different contexts. The issue about the rural areas was to preserve access. So the question is do you want every physician in an urban area, because they're getting higher payment, to take on these procedures? So focus on the access, don't focus on what the particular costs are of an individual provider.

DR. BORMAN: Could I just ask as we take this analysis forward where one of the things we say we're going to look at is more bundling in surgical procedures with related services, at the risk of increasing the complexity I think there's an important differentiation here between major procedures and so-called minor procedures. Depending on how you want to define that, the definition that certainly is within the program is zero to 10-day globals versus 90 day globals. And I think there are some real

differences both in the margins and in the things that group up with them and the kinds of things that are done.

So if we're going to drill on that, I'd like to see us start out drilling down on sort of a dichotomous model because I think there will be differences.

MR. HACKBARTH: You're talking about on the physician payment side, as opposed to the hospital outpatient department payment?

DR. BORMAN: I have to say I'm not entirely sure because the things that match up on the hospital side to the physician side, I think have some of the same relative relationships to each other as are reflected within the physician services. There's this hugely important piece that's already been mentioned of the very expensive device. But then I think there's also the issue of things that are more isolated, as the minor things tend to be, versus something that extends over a period of time that allows more things to be grouped up into it. Just like when we looked at episode groupers, as you spread out the interval you aggregate more. And by definition, on some of these minor things, you're talking about a very short delimited

thing both for the hospital and the physician or the ASC and the physician or whatever.

DR. CROSSON: If we can look at slide 11 for a second, this may be a small point but I think perhaps not in the end. And it has to do with the elegance of language. When I read the paper the first thing that struck me was the notion that economies of scale create inequities. I don't think that's the case. To say nothing about the substance of the need in rural hospitals or anything like that.

But through the document here and other places there's almost an assumption that economies of scale create inequities, therefore economies of scale are bad and ought to be punished. And I don't think that's what we mean.

MR. HACKBARTH: For sure that's not what's meant. When we talk about the low volume adjustment concept, and Dan pointed this out in his presentation, we're talking about a particular subset of cases where we have institutions that we think need to be protected for reasons of access and they're relatively isolated, however we measure that, and Nick's legitimate concerns about mileage only being the appropriate measure.

And so the starting point is we need these institutions, the patients need these institutions. How do we make the payment system fair to them? That's the type of equity that we're talking about.

DR. CROSSON: My thought is that that ought to be the entry point, whereas it seems a little bit in the paper the entry point is that we've got these inequities that are consequences of economies of scale and therefore we have to do something.

MR. HACKBARTH: We don't want to protect the low-volume provider in Manhattan because it's inequitably treated by the payment system, yes.

DR. MILSTEIN: I would find it valuable if in the next iteration of this, as long as we're modeling different tweaks, to be able to have an understanding as to what would be the implications if we took a page out of CMS's recent very progressive policy with respect to anticipating DRG coding changes.

Essentially, what CMS did is rather than wait predictably to find out how much payment inaccuracy was associated with changed coding, they looked back historically and said this is about how much we can expect

in the way of coding creep to offset our desired changes. So let's just build that in up-front to the payments.

Is there an analogous opportunity here with respect to our approach to the first two years of covering new technologies? We know based on historical experience we end up overpaying for new technologies by about X percent, whatever that turns out to be. Could you give us a sense as to what the implications would be if we said okay on a going forward basis we know on average we're going to be overpaying for new technologies by X percent. Let's consider up front discounting how much we're paying for new technologies in the first two years so we're not playing catch-up two years later.

MR. HACKBARTH: I think the problem, Mark and others correct me if I'm wrong, is that we don't have a good take on what that right payment level is in the first --

DR. MILSTEIN: I thought the presentation suggested it's been studied and in 19 of 25 cases we have overpaid. Didn't you just say that?

DR. ZABINSKI: That's relying on historical data. That's sort of like going after the fact.

DR. MILSTEIN: When we're anticipating the coding creep we're making future projections based on what's gone on in the past. So it would be no different than that approach.

MR. HACKBARTH: Maybe I'm just misunderstanding what you're standing. We don't have actual cost information so we use methods to try to set that initial price. And you would say okay, we set whatever we think that initial price is and then we reduce it by 20 percent because we've found in the past that that's the slope as we actually do get cost information.

DR. MILSTEIN: Exactly.

DR. REISCHAUER: The problem with that approach is then the innovation won't be adopted as rapidly. Now you might say that's fine.

DR. MILSTEIN: I agree with that implication but all things considered...

DR. SCANLON: The other issue with this method is that depending upon those methods that we have for setting the fee and depending on how much they rely upon data from some source, if the source knows it's going to be discounted 20 percent, they move it up.

DR. WOLTER: I just wanted to say because of Arnie's using the analogy of the behavioral offset, I think there are some of us who worry about that as a policy because in my view it's going to hurt the organizations that code appropriately. So instead of targeting some way of maybe auditing to see who's inappropriately coding, we're using a sledgehammer that may hurt those who are doing things the right way. And possibly the behavioral offset will incent more inappropriate coding than it weren't being applied prospectively. So I worry about that becoming a model for other things.

DR. MILSTEIN: Point well made and I agree with that comment.

That said, I think that as applied in this circumstance we're not talking about differences in inter-provider adaptation. We're saying that our past sources, which I understand are external sources, on predicting what it's actually going to cost, turned out to over-predict, you know how much it costs hospitals to deliver this, by a certain percent. So let's make that adjustment.

That approach would not then replicate the concern that you have with respect to behavioral offsets

with respect to coding adjustment. It's simply saying look, this external information that on average is being used to predict cost turns out to systematically over-predict. And so let's up-front adjust for it.

It's not really a behavioral response adjustment. In invoking the example of what CMS is doing with respect to DRG coding creep, I was more trying to focus on the idea of making an anticipatory change rather than an offsetting behavioral adjustment, which is what was occurring.

DR. DEAN: Do you have to specify that in advance? Or do you just need to say that there needs to be a new look down the road a little bit as to what this is actually costing?

MR. HACKBARTH: Let's hold off on that for now.

We have more than the usual number of loose ends dangling on this conversation. I think in part that's a reflection of it being a new topic, something that we haven't focused on. It may also be a function of the hour, at least for me.

What I do think is that this is an important payment system. As Nick indicated, it's one where -- this is where more and more of the business is going. And so

it's worthy of a significant investment of resources to try to get it better, if not right.

In doing that, I don't think we will necessarily be able to address all of the issues, all of the dimensions of this that came up to make it a manageable product. We may have to exercise some judgment about defining the scope of this and look to Mark and Sarah and the staff to help us think through how much we can reasonably take on in this and still have a manageable project.

Thank you, Dan, for introducing this topic.

We will now move to our last session for today which is physician resource use measurement. This one is not a new one. This is an old friend, and we have some information from some site visits.

MS. PODULKA: We are the last session for today and we will be presenting some preliminary findings from site visits that we conducted over the summer to private health plans that use episode grouper software to measure physician resource use. These site visits were designed to seek answers to your questions about how plans have rolled out these efforts.

They were conducted in conjunction with Mathemetica Policy Research and they will be issuing a full report later this year. So we'll let you know when that's available.

The findings that will result will complement the methodological work we have completed thus far that explore how episode grouper software packages work with Medicare data.

We visited health plans, local medical associations, and multiple physicians in four locations: Austin, Boston, Cleveland, and Seattle. The plans we spoke with represented a mix of national managed care companies, BlueCross BlueShield plans, and local independent plans. Multiple health plans, not just the ones that we visited, were implementing both quality and resource use measurement in each of visited markets.

The health plans that we talked with have multiple years of experience using episode grouper software to measure physician resource use. Plans were using one of the software packages that we've used with Medicare claims data, either ETGs or MEGs. Plus plans were also using two

software packages, the Cave grouper and Anchor Target Procedure Groupers, or ATPGs.

Three of the plans that we visited with used a gated approach to measuring physician resource use where they first require that physicians meet quality measurement standards and only then measured physicians on their cost efficiency. The fourth plan that we talked with measured both quality and efficiency simultaneously and independently.

Plans have multiple uses for the results that they get from both the quality and resource use measurement. First, they use it for feedback to physician. And for new commissioners, the Commission recommended that Medicare do this more than two years ago. They also used the results for creation of network tiers within existing HMO or PPO products or, alternatively, for the development of lower cost products built around a smaller high-performance network. Results are also used for pay for performance style bonuses and/or reporting targeted to consumers, such as Web sites that indicate physicians awarded with gold stars for high quality efficient care.

Plans did not measure all physicians and the number of specialties included in their quality and resource use measurement varied by health plan. Three of the plans we spoke with focused on a range of selected specialties -- eight, 12 and 16 respectively -- while the fourth plan included nearly all specialties that provide direct care to patients.

There were two main factors that affected the choice of which specialties to measure. First was the availability of well-established quality metrics on which to judge them upon. Second was a perceived necessity of keeping some specialties in their network or preferred tier for access reasons. These reasons included a strictly limited supply of a certain specialty such as a single neonatology practice in town, and more nuanced decisions such as keeping bilingual physicians or keeping all oncology practices.

Since the purpose primarily of our site visits was to gather information about resource use measurement, Megan will now focus on these efforts.

MS. MOORE: Thank you, Jennifer.

Most plans we talked to focused the majority of their time and effort on the methodology of resource use measurement. Plans deal with the same methodological issues MedPAC reported on as we used episode groupers to analyze Medicare claims such as minimum number of episodes, attribution rules, treatment of outliers, and price standardization.

Plans have made different decisions about all of these issues and many plans are continuing to make modifications to their methodologies as their programs evolve. In other words, there is still much experimentation in the field of physician resource use measurement.

However, in some cases we do see consensus. For instance, plans tend to measure research use based on contracted rates so they measure both price and volume differences. In contrast, we standardized payments for our analysis to exclude price comparisons. Using contracted rates may make sense for a health plan, but may be less appropriate for Medicare because of the numerous policy-based adjustments to payments, such as the additional payments made to teaching hospitals.

In contrast to the time and effort put into the methodology, most plan's communication and education efforts to rollout resource use measurement results to physicians seem limited and poorly designed. While plans generally directly engage organized stakeholders such as state medical societies and large group practices, efforts aimed at reaching individual physicians and doctors in smaller group practices varied by plan and were often less direct. Most often communication is through websites or letters and interviews with physicians indicated that many of these efforts where ineffective. For instance, some physicians said they first heard of specific efforts to measure their resource use when they received a letter with their score or designation.

All plans provided feedback reports to physicians that at a minimum included an overall efficiency score or a designation of efficient inefficient but some plans' feedback reports also included more detailed information.

Plans mentioned the trade-off between providing more detail to providers to increase transparency and actionability and limiting information to keep these reports understandable. Plans generally handle physicians'

questioned about feedback reports by phone and reported initial problems with customer service representatives being unprepared for this task. They noted that this type of one-on-one communication can be very time and labor intensive. Plans also acknowledged the need to refine their communications with physicians and some have made changes after their initial rollout of resource use measurement.

Now Jennifer is going to talk about the physician response.

MS. PODULKA: Physicians' reactions to health plan measurement efforts ranged wildly. Many physicians actually had no direct knowledge of resource use measurement but tended to be skeptical about the plans generally. When physicians did have direct knowledge, some strongly opposed the programs and expressed dissatisfaction with specific aspects of measures, especially when applied to their own practices. However, we also spoke with physicians who expressed general acceptance of resource use measurement and even used the feedback to perceive quality and efficiency improvements their own practices.

We learned that in cases where plans measure resource use at the physician group practice level, feedback to the group may not always be shared with individual physicians. For example, one physician we spoke with who regularly received feedback while he was in solo practice stopped receiving any reports once he had joined a group practice.

Some of the specific concerns raised by physicians begin with a lingering basic concern about the validity of resource use measurement methodology, many of the same things we've dealt with such as attribution and risk adjustment.

Specifically something that was new for us was that several physicians were critical of plans comparing their unobserved spending to their average or expected spending, the same way we do for our own methodology. They felt that comparing observed to expected made them meet a moving target each year and was less fair than pay for performance systems where they're required to meet a benchmark such as providing a service to 80 percent of their patients.

Secondly, physicians were concerned about inconsistency between multiple plans' different approaches to resource use measurement and different performance measurement results. Physicians told us sometimes they were ranked as inefficient with one health plan and efficient with another.

Third, as Megan mentioned, physicians reported a perception a little communication from plans about the details of measurement efforts, although physicians also acknowledged that they don't always have time to read and absorb the information that they receive.

Physicians also expressed a concern that when health plans share this information with patients and consumers, they may not always understand how to use it appropriately. Specifically there are instances where physicians aren't measured because of a lack of metrics and therefore don't have an opportunity to earn a high score and they want to make sure that their patients understand the difference between scoring badly and not having the opportunity to be measured at all.

And finally, even physicians that were largely supportive of resource use measurement had strong concerns

about what they perceived as the plans' disregard for impact of patient behavior on their resource use measurement scores. They argue that, similar to risk adjustment where plans control for patient's health status, plans should also consider a myriad of patient behavior issues such as adherence to plans of care, adoption of healthy lifestyles, ability of patients to pay for services and prescription drugs, and patients coming in with demand for specific expensive services.

And finally, the interviews that we conducted revealed little evidence of savings thus far from these measurement efforts. Plans explained this, at least in part, by the fact that they have not used resource use measurement results from major payment or network reforms with large effects on the market. Plans tended to have relatively small market shares in each city we visited and they sometimes found themselves with less purchaser support than what they had started off with when they began the programs.

The focus of the market efforts to date has been on reporting to physicians and consumers and only in some limited instances have they been used for financial

incentives for consumers to use physicians in preferred tiers or high-performance networks.

However, despite the lack of significant savings, all of the plans we spoke with see physician resource use measurement as the future and all have plans to continue, improve, and expand their programs.

So we sort of have a set of impressions that we gained from these conversations with private health plans and we're very eager to hear your ideas on how to apply what we've learned to the Medicare program.

MR. HACKBARTH: Can I ask for just an update on an issue we've discussed before that Arnie has raised numerous times? That is making Medicare physician data available so private plans and others can use it, but maybe hopefully be able to pool Medicare data and private data so that for individual physicians we've got a more complete database to use for evaluation.

What made me think of it was the comment from individual physicians that they get a good rating from one plan and a poor one from another, which could be a function of the limited samples that people are having to work with to do this analysis.

There has been in the news the stories about a lawsuit to require CMS to make that data available for analysis. Do you know what the status of that is? Or does somebody know?

DR. MILSTEIN: The Federal District Judge issued an order requiring the Secretary to share the requested beneficiary encrypted Medicare claims data with Consumers Checkbook and the appeal period for -- the period under which CMS could appeal that decision has not yet expired. That's the current status.

MR. HACKBARTH: Have they made an announcement about whether they plan to appeal?

DR. MILLER: It's a clear precedent but the lawsuit pertains to I think three states. It's like Virginia, Washington and D.C.

DR. MILSTEIN: What was requested initially was deliberately less than what would be needed to support full robust physician performance measurement using Medicare pooled data with private sector. The initial focus was just on identifying Medicare surgeon volume for that subset of surgeries shown to be volume sensitive -- whose outcomes have been shown to be volume sensitive.

But the Consumers Checkbook has announced that the follow-on FOIA request will pertain to all 50 states and pertain to the full Medicare data.

DR. REISCHAUER: Isn't there another lawsuit against Aetna for doing this?

MR. HACKBARTH: In fact, thanks for raising that, Bob. It would be useful, not everybody knows about that. So Andrew Cuomo, who is the New York Attorney General, has filed suit against Aetna for --

DR. MILSTEIN: No, he has not filed suit.

MS. BEHROOZI: He hasn't actually filed suit. He's just called them in -- against United, right?

DR. MILSTEIN: He has requested information. That's all. But there is a lawsuit filed by a physician group in Connecticut against two of the national insurers, saying that physician performance measurement and use of it to create premium physician networks violates various Connecticut statutes.

MR. BERTKO: [off microphone] Then there was a settlement with Regence in Seattle of some sort.

MR. HACKBARTH: Now that we understand the playing field, Arnie go ahead.

DR. MILSTEIN: A couple of comments. First of all, terrific and obviously it's an area of investigation I'm very supportive of. But a couple of comments.

First of all, I think it's important to realize that inter-insurer variation on physician efficiency ranking is neither surprising nor does it imply any validity problems. Because remember that in the private sector, where we don't have administered prices, physicians and/or the suppliers that they use, such as an MRI facility, can vary substantially in the unit prices that they charge to one insurer versus another. And so that variation would actually explain -- one would be surprised if physician efficiency rankings in the non-Medicare world were identical across insurers. That's comment one.

MS. PODULKA: [Inaudible.]

DR. MILSTEIN: It's not a question. I'm just saying it doesn't imply any problem. Listening to the presentation, one might worry that physician complaints are related to some fundamental underlying validity problems. They might be, as Glenn mentioned, related to small sample sizes. But the fact that they rank differently is in no

way a prima facie case that there's anything invalid about the methodology. That's my point.

MR. HACKBARTH: Although Arnie wasn't asking a question, if you want to take objection you can feel free to.

DR. MILSTEIN: Please respond before I go on to my next point.

MS. PODULKA: No, we didn't see that as a problem of face validity. What we were trying to focus on -- although we kind of got sidetracked because we like to geek out a little bit and talk about the methodology when we're in the room with people who are doing this -- we were really trying to focus on the rollout efforts.

When we spoke with physicians they said I get two or three reports: one I'm good, one I'm bad, one I'm not eligible because of small sample size. I'm a physician. I don't know what to make of this. What do I change about my practice?

For us, we kind of feel like we've gotten a little further on methodology. This whole rollout thing is a whole new area for us.

MR. HACKBARTH: That's the perception which we have to deal with even if it's not accurate or valid.

DR. MILSTEIN: A second comment relates to the perception on the part of plans of no savings. I would just like to ask whether or not that might be actually a byproduct of the small sample size. Because essentially, for most of the private purchasers I work with all over the country, they can get a substantial reduction in the premium they pay, which is the ultimate test of whether it's saving money, if they will install a network that either is limited to the physicians that score better on these metrics or is tiered with respect to beneficiary coinsurance in a way that encourages patients to at the margin tilt toward the doctors that score more favorably on quality and efficient resource use.

So I'm concerned that we looked at four markets and had we instead gone to the actuarial department of the national insurers that are actually looking at their claims experience and then pricing premiums accordingly, we would have seen evidence of substantial savings which was also, if you look in the appendix to the GAO report on

recommending that Medicare does this, also cited a number of examples where the savings were substantial.

The last place you might look is in the PacifiCare testimony in front of House Ways and Means about two or three years ago because they were kind of early on this. I think their quote for the record was something like a 10 to 20 percent difference in their so-called medical losses associated -- they were looking at physician groups rather than individual physicians -- that's scored more favorably on quality and efficiency.

MS. PODULKA: I do definitely want to jump in there. It was not evidence of no savings. It was limited evidence of savings. Plans fully acknowledged -- in many ways, they're taking baby steps in how to use this to impact both their purchasers, their patients, and their physicians. In only one instance of the plans we spoke to -- and you're absolutely right it's four. We can't necessarily generalize what we learned. But it only one instance was it being used for a payment differential to the physician.

Certainly where they're having a selected high-performance network that you can purchase into they were

very excited, they can price that differently from their other products.

So there are savings occurring. So far, in many instances there's either no teeth to these products or only baby teeth to these products. And the plans told us we don't see big savings yet but we're not really trying to move a lot of market share or consumer activity here.

MR. EBELER: Hospitals in particularly big systems do some of this same type of thing where they look at their medical staffs and roll out yet another set of data to them. Did any of these plans link with those and try to see what the combined results would be or not?

MS. PODULKA: One of the markets we spoke with there was a plan where there was a distinctly large hospital system and they have had ongoing conversations. But probably not too surprising, when hospitals pursue this and have a history of their own efforts, they've purchased their own software, they have their own culture and it's not instantaneous for the two to mesh.

MR. BERTKO: Just a quick comment. I think that the site visit and what you learned from them are very important. If you were to go to, I guess it's slide nine,

this strikes me as foreshadowing about accountable care organizations. And were you to replace resource use with accountable care organization rollout, I would worry you get some of the exact same type of things. What's the validity of the methodology? What do patients do with it, et cetera? And so maybe we take a lesson here on anything we put forward in that area to say this is the kind of result we should anticipate.

DR. BORMAN: Just two comments, one to directly follow up with Bob's observation. I would say that don't necessarily take a negative or a pejorative assessment of that. Part of what physicians are trained to do is to pick apart a problem and then to deal with the pieces of it. And so the behavioral response here reflects some of that and not necessarily pushback at you're trying to get us to do something we don't want to do or don't cut into my income or whatever. I would want to be a little bit careful about just making sure we all understand that part of this kind of response is a result of a lot of years in school or training or whatever that lead you to that kind of response.

The thing I did start out wanting to say was I share with Arnie that I think this is a really important area of information. My sense is that there's low hanging fruit to be had here and we're desperately seeking for things that are low hanging fruit to, as Arnie says, get there and how we do it quickest.

I would say that I would perceive that there is opportunity here to really get physician stakeholders involved in this. And here's where I think it lies. As you probably know, Glenn, from your work with the ABIM Foundation, and I think Nancy-Ann you've been exposed to that before, all of the specialty societies are in a process of converting from recertification to maintenance of certification. A piece of that is assessing your own practice. That is a universal requirement of all the specialties in order to have their MOC process certified.

So reporting back data to the physicians that they can then demonstrate they did something about, where somebody else is doing the work of getting the data and then getting you the data after you did your intervention, has the value to me as a practitioner of enabling MOC for me with less hassle.

Now you can either pay me more or you can remove my hassle. So since we're not talking about paying me more, other than perhaps in a quality setting, let's do something to cut my hassle. And I think this is a real opportunity area to do something like that.

MR. HACKBARTH: I think that's a good point, Karen. I know some of the societies are thinking about serving as data repositories for physicians. So physicians submit data to them or they receive reports from insurers and others and physicians don't have to do duplicative reporting and the like. They've got some support in dealing with all of this. Potentially that could be very significant for physicians.

DR. BORMAN: But a lot of the problem with the society things is it's self-reported data. And while that's better than no data, it's kind of not -- eventually it's going to have to get to an iteration of not self-reported data. And this would jumpstart it past that.

MS. HANSEN: A question on this particular slide that raises for me the impact on how patients will perceive this. That raises for me just the curiosity of what has been the impact of the CMS reports on Hospital Compare and

Nursing Home Compare? Has that really affected patient behavior in any way that's kind of notable? It's on the web. So the whole question is what has been the impact of that?

MR. HACKBARTH: Do you know, Jennifer?

MS. PODULKA: I don't know off the top of my head. It's a good question and we can look into it. I know both for CMS with those websites and also for the plans, in part they're directed at consumers. And certainly CMS's case they're also directed to the state health insurance counseling programs and adult -- children of patients.

So I think the thought of having it not there is sort of something people would clearly want to avoid at this point but I'm not sure how much impact it has on direct consumer decisionmaking.

MR. HACKBARTH: We can take a look and see if we can pull together some information on that.

MS. BEHROOZI: On the subject of physician buy-in and just turning back to the Andrew Cuomo issue, it's not that -- as some of us who are paying attention to this

because this is the kind of thing we want to do to make our own plans more cost effective.

It's not that there's something intrinsically illegal or it's not like antitrust issues or anything like that. As we understand it what he's being motivated by is the provider community that's saying that these rankings are deceptive when it comes to what the patients understand that they're learning because words like efficiency are really euphemisms for cost. And when you're talking about for-profit insurers, no offense, the charge is that it may be efficient for those insurers to reap the benefit of the lower cost docs but it's not necessarily of greater benefit to the patients.

And that seems to be what's in his mind.

MR. HACKBARTH: So is it a matter of the presentation and packaging? Or are they also raising questions about the validity of the data and methods? Or some combination of all of the above?

MS. BEHROOZI: That seems to be swimming around underneath it. It seems to be like a whole bag of charges that the provider community is lumping together.

But I think the thing that the AG's office feels like is the most legitimate thread for them to pursue is whether the consumers are being -- patients are being served by this in the way that it appears that it's being portrayed that they are.

DR. DEAN: Just to follow up on that, I think it's an important issue. It depends on how this information, who it's really focused to. If it's focused to insurance plans and physician societies, it will be used one way. I think, from what I know, and I'm certainly no expert, but when this data is put into the public's hands it's very hard to interpret how it's going to be used. Sometimes it's very counterintuitive.

There was a study in Health Affairs just a few months ago about how people make the decision on Lasik surgery, which they thought if ever there was a procedure where people would be encouraged to be intelligent consumers, they're paying for it out-of-pocket, it's elective, it's all those things. In fact, their conclusion was that they made their choices based on how their neighbor did. They were very suspicious of low-cost providers. All of the counterintuitive stuff.

So I think just saying that people will interpret this data the same way we do is not true.

MR. HACKBARTH: That's a great segue to what I was going to say. Keep in mind that MedPAC's recommendation on this has been, as a first step, to share these data with physicians on a confidential basis, in part because we wanted to do it in a way that increased the likelihood of a positive response from physicians, as opposed to a defensive response. I still think that that is a wise choice.

To me the overriding message of Megan and Jennifer's report is boy, you really need to invest -- not as much as -- more in the implementation of this than you do in the crunching of the numbers if, in fact, you want to evoke a positive response and not a defensive one and you want people to change their behavior.

I think that's always a risk. It's a risk for private health plans. I think the risk for Medicare is much, much larger because of the scale of the operation and the resource issues that they have that Bill has so often pointed out.

So I think these findings are very important and worthy of our consideration and CMS's as we move forward with this.

We are at the end of our agenda for today.

We'll now have a brief public comment period, and our usual ground rules apply which are number one, please identify yourself if you go to the microphone. And two, keep your comments very brief. And three, if someone before you has said what you want to say, you don't need to repeat it. Just say I agree with so-and-so.

Any public comments?

I didn't mean to deter people. I'm not that scary.

Okay, seeing no one at the mics, we are adjourned for today and we can we reconvene tomorrow morning at nine o'clock.

[Whereupon, at 5:29 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, September 7, 2007.]

# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Friday, September 7, 2007
9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
THOMAS M. DEAN, M.D.
NANCY-ANN DePARLE, J.D.
DAVID F. DURENBERGER, J.D.
JACK M. EBELER, M.P.A.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, PH.D.

AGENDA PAGE



P R O C E E D I N G S

MR. HACKBARTH: Good morning. The subject of the day is appropriate use of imaging services. Ariel, you'll do the introductions? Thank you.

MR. WINTER: Good morning. We are pleased to have an expert panel here today to discuss ways to ensure the appropriate use of Imaging studies.

I will start things off with data and background information and then we'll proceed directly to presentations from our three panelists. Afterwards, there will be plenty of time for discussion and questions.

I know that we're eager to hear from the panel so I'll try to keep my remarks brief and there are more details in the paper I've sent you.

Before I start, I want to thank Megan Moore for help with this paper and presentation.

The main points I would like to make are the technological progress in imaging has contributed to significant improvements in diagnosing and treating diseases. Yet there are concerns about the rapid growth of imaging services, variations in the quality of providers, and potentially inappropriate uses of imaging. We'll be discussing options to encourage more appropriate use of these services.

Imaging technology has advanced rapidly in the last few decades. Innovations in electronics, miniaturization, and computing power have made imaging machines faster, smaller and more precise. Several clinical studies have shown that imaging can improve diagnosis and treatment for certain conditions and there are some examples listed on the slide.

Once an imaging technology defuses widely, however, it is unclear whether it produces significant clinical benefits in all cases.

This chart shows that diagnostic services paid under Medicare's physician fee schedule grew more rapidly than any other physicians service between 2000 and 2005. While the sum of all physician services grew by 31 percent, as indicated by the red line, imaging services grew twice as fast, by 61 percent, during those years. This measure reflects the growth in the volume and intensity of services per beneficiary. We've adjusted for changes in prices.

Some have claimed that growth of imaging under the physician fees schedule represents a migration services from hospitals to non-hospital settings. However, we found that per capita spending for imaging provided in hospital outpatient departments has also been growing recently, by 2.5 percent in 2003, 6.2 percent in 2004 and 5.4 percent in 2005. These numbers do not include the effects of annual payment increases.

This shows that growth in on physician fee schedule imaging has not been offset by a decline in outpatient department imaging. What we find instead is

that physician fee schedule imaging accounts for a growing share of imaging services paid under Part B.

When we examine the growth rates for specific types of services, we found that MRI, CT, and nuclear medicine studies, which are among the most expensive exams, grew fastest between 2000 and 2005. In dollar terms, spending for imaging services paid under the physician fee schedule, including beneficiaries' cost sharing, nearly doubled between 2000 and 2005, from $6.4 billion to $12 billion.

Increased spending has also led to higher Part B premiums for beneficiaries. More than one-third of imaging spending is for CT and MRI scans, which reflects both the rapid growth and higher payment rates for those services.

Several factors could be influencing the growth of imaging services. First, there are advances in imaging technology, which we mentioned earlier. Second, several factors have created opportunities to perform imaging studies outside the hospital setting. Technological developments have resulted in smaller, cheaper, and more portable machines which makes it easier to perform imaging in physician offices.

In addition, equipment manufacturers often offer assistance to physicians who acquire equipment for their offices, including help with cash flow analyses, design, financing, and maintenance.

The ability of physicians to offer imaging in their offices probably leads to better access and convenience for patients. However, this does have implications for quality oversight because Medicare does not set quality requirements for imaging performed in physician offices, in contrast to imaging furnished in hospital outpatient departments.

The third factor is consumer demand, fueled in part by direct to consumer advertising.

A fourth factor is defensive medicine, when physicians order tests due to a concern about malpractice liability. According to a recent study by Baker, Fisher, and Chandra, states with faster growth in malpractice payments per physician experienced more rapid growth in imaging spending. When we apply their results nationally the increase in malpractice payments explains about 3 percent of the rise in imaging between 1993 and 2001.

A fifth factor are incentives in the physician fee schedule. In our 2006 report we described how CMS may be overestimating the cost of CT and MRI machines, which could lead to overpayment for those services.

A final factor is physician's interest in supplementing their professional fees with revenue from ancillary services. According to a survey sponsored by MedPAC in 2006, almost 20 percent of physicians reported that they increased their use of in-office imaging in the past year.

The increasing use of imaging in physician offices may be contributing to volume growth. Research has found that physicians who own imaging machines tend to order more studies for their patients.

The rapid growth of imaging raises questions about whether these services are always used appropriately. MedPAC, as well as researchers at Dartmouth, have documented wide geographic variations in the use of imaging as well as other services. These variations are linked to differences in the local supply of physicians and hospital resources and are not associated with improved outcomes.

There's also some specific evidence of underuse, overuse, and misuse of imaging studies.

This slide has some examples of underuse. One example I will mention is the Commission's finding that Medicare beneficiaries do not receive mammography screening for breast cancer as frequently as recommended.

In terms of the overuse, research suggests that imaging is used too frequently to treat patients for low back pain, a very common condition. According to guidelines developed by the American College of Radiology, patients with uncomplicated acute low back pain, that is without serious risk factors or signs of serious pathology, should not receive imaging studies. Fewer than 1 percent of imaging studies detect the cause of low back pain and most patients return to their usual activities within 30 days. Researchers have found, however, that about one-fourth of patients with uncomplicated low back pain received imaging studies within the first 28 days.

There's also evidence of misuse. Several research studies have found that there are variations in the quality of imaging providers. If a study is performed by a low-quality provider, the exam might have to be

repeated. In addition, a low-quality study could also lead to incorrect diagnosis and improper treatment. For example, one study found that non-accredited ultrasound providers often produced carotid ultrasound tests that did not accurately measure disease severity. Tests that overestimated severity could have led to unnecessary surgery for patients and tests that underestimated severity could have resulted in no surgery for patients who needed it. These concerns led the Commission to recommend that the Congress direct the Secretary to set quality standards for all providers who bill Medicare for imaging services.

Inappropriate use of imaging can have significant consequences. First, the use of services that provide little clinical value for patients means that Medicare and beneficiaries are not getting good value for their dollars.

Second, patients do not receive clinically recommended studies such as mammography screenings may suffer from worse health outcomes. When patients receive the wrong study or a poor quality study there may be delays in diagnosis and treatments.

In addition, Elliott Fisher and Gilbert Welch have pointed out that overly aggressive use of imaging to

detect disease may pose risks. Imaging can detect abnormalities in areas such as the back or the knees, for example, that frequently do not affect the patient's health. Detection may cause patient anxiety and lead to follow-up testing and treatment which may have only a limited chance of improving outcomes.

Finally, exposure to ionizing radiation from CT scans, nuclear medicine studies, and x-rays may increase the risk of developing cancer. This heightens the importance of using imaging prudently.

This slide lists a variety of ways in which researchers, physician groups, manufacturers, and payers can encourage more appropriate use of imaging. This is not a comprehensive list and we're certainly open to other ideas. We'll briefly review each of these options.

Some physician groups, such as the American College of Radiology and the American College of Cardiology, have developed guidelines to help ordering physicians decide which study is most appropriate for a given clinical situation. These criteria are set by expert panels that review evidence from the medical literature. Because empirical evidence is often insufficient to set

guidelines, the panels also use clinical judgment. Dr. Douglas will be talking more about this approach.

Another option which complements the first one would be to perform more research on the impact of imaging studies on diagnosing and treating patients. Some experts have pointed out that there's not enough empirical evidence on this issue. Such research would help physicians and patients make more informed choices. It would also improve the evidence base for developing appropriateness criteria.

CMS has developed an approach to cover new technologies called coverage with evidence development, in which the Agency collects information about a service's clinical effectiveness through registries and clinical trials. In the past, CMS might not have covered these services because of inadequate data about their effectiveness. For example, CMS has agreed to cover PET scans for certain kinds of cancer when the patients and physicians participate in clinical trials or submit data to a patient registry. CMS intends that these data collection efforts will be used to assess the impact of PET scans on patient management. This model could perhaps be used to evaluate the impact of other types of imaging services.

Another issue to mention here is the Commission's recommendation on comparative effectiveness from last year.

It might also be worth thinking about better ways to communicate research findings and appropriateness criteria to physicians so they can use them in their daily practice. For example, some software developers have incorporated guidelines on imaging into their clinical decision support tools. Physicians can input the tests they want to order along with clinical information and get feedback on whether the test is appropriate.

Another option is for payers to measure whether physicians order clinically recommended studies such as cancer screenings. This information could be provided to physicians as confidential feedback or it could be incorporated into a pay for performance system.

Finally, several private plans require that physicians receive prior authorization when ordering expensive studies such as PET, CT, nuclear medicine, and MRI. The goals of these programs include ensuring appropriate use of high-tech imaging, educating physicians about clinical guidelines, and controlling the growth of imaging spending.

Plans often contract with radiology benefit managers, or RBMs, to develop and administer these programs. We interviewed five RBMs and eight plans to learn more about how these programs work. First, the RBM develops an algorithm that determines whether a given study is appropriate for a particular indication based on appropriateness criteria, medical literature, and physician panels. When a physician submit a request order a study to the RBM it uses the algorithm to decide whether the study is appropriate and should be covered.

Some plans require prior notification instead of preauthorization. In these programs, the ordering physicians tell the plans which studies they want to order and the plans give them feedback on whether the studies are appropriate. If a study does not meet clinical guidelines the plan will suggest an alternative approach but does not deny payment if the physician wants to order the study anyway.

The other key findings from our interviews are described in the paper we sent you and summarized in the next two slides, which I'm not going to spend time on so we can get to our expert panel.

I'd like to now introduce our panelists and invite them up there to the table. Their bios are in your binders so I'm not going to detailed introductions.

First, we have Dr. Carey Vinson, the Vice President for Quality and Medical Performance Management at Highmark.

Second, we have Dr. Pamela Douglas, the Ursula Geller Professor for Research in Cardiovascular Diseases at Duke University Medical Center.

And third, we have Dr. Patrick Courneya, the Medical Director for Delivery Systems at HealthPartners Health Plan.

I'm going to pull up Dr. Vinson's slides and get out of the way.

MR. HACKBARTH: Ariel, that was a terrific summary and introduction. Welcome to all of our guests. Dr. Vinson, whenever you're ready.

DR. VINSON: Good morning. Pleasure being here.

Highmark is the BlueCross BlueShield plan in the Western Central part of Pennsylvania. And what I'm going to describe for you -- the history of our program was that Highmark started a utilization program in the past, in

1997, when it first became clear to us that there were problems with the utilization of imaging services that were increasing much faster than the utilization of other medical services.

So we decided at that time to begin with a very limited provider privileging, where we wanted the practices that were performing outpatient imaging services to have minimal qualifications primarily to look to see that the doctors were credentialed in our networks, that they were using appropriate technical assistance such as certified technicians in their offices.

We also started a preauthorization process that was limited to CT, MRI, early PET scanning, as well as nuclear cardiology and bone density testing.

We started also, for the first time, to do some provider profiling to see exactly why and under what circumstances images were being ordered.

We thought the program was fairly successful. We saw a moderation of the trend with the imaging to the point where the rate of increase was still going up but it was along the same lines as what we were seeing with other medical services. The plan also was backing away from

utilization management at the time, going more with a PPO-type of program and decided to remove most of the preauthorization components at that time. But we continued the privileging program.

And what we saw, unfortunately, was within weeks after stopping the prior authorization program the utilization trends went up to what they were before we started the program. And over the next 12 to 14 months the increasing utilization trend accelerated. Whereas on a national trend, according to the studies we were seeing, imaging utilization was going up 9 to 12 percent, at Highmark it was going up 22 to 30 percent per year.

A lot of discussion internally as to why this was occurring. I think a lot of the same thought as Ariel was describing played into our considerations.

One of the consultants we used came up with this graph that showed CT and MRI utilization in the Highmark regions was much higher than most of the country. I don't know if that's just because our practitioners were ahead of the clinical standard of care or what, but it was somewhat disturbing to us as to why we were seeing such outlying trends.

So what we did was go back and start again. We got proposals from vendors. We decided to use an outside vendor to run the program. We selected National Imaging Associates. This was the group that had worked with us in 1998, we went back to them. But this time we decided to do things a little differently. We decided to increase the privileging part of the program to now cover all outpatient imaging services, rather than just CT, MRI, and PET.

We also went to reinstitute prior authorization. But we decided we would have a middle section or a middle phase where we would have prior notification, just teaching the physicians how to order appropriately. The idea was we wanted to reduce utilization to appropriate use of the tests, not to flatten the trend inappropriately but just to encourage the physicians to order the necessary tests. We also wanted to make certain that the practices that were performing the services were adequately trained and were using the right types of equipment and support services.

I'm not going to spend time on privileging because my understanding is the commissioners have heard about our privileging program before. So I'm going to move to slide 18 and talk about the prior notification.

It was voluntary. There was no denial of payment. What we did ask is that the physicians and other clinicians, when they ordered the imaging test, would call in and get -- in this case it wasn't an approval, but they would know if the request was meeting the guidelines.

The guidelines were developed based on the American College of Radiology guidelines. They were reviewed and modified by our Practicing Physician Oversight Committee. We also wanted to make certain that our guidelines conformed with our medical policies. In other words, that our benefits were totally in line with what we were approving or denying.

We did also decide to limit the prior notification to CT, MRI, and PET services. And what we discovered is since there was no denial of payment, the physicians didn't take the opportunity to call us. Our participation rate was less than 10 percent. Maybe we shouldn't have been surprised but that's what happened.

So my advice to anyone who's thinking about prior notification, maybe skip it. But the idea was we wanted the physicians to become familiar with our program. We wanted the physicians to see the criteria so we could get

feedback about whether the criteria was correct. We also wanted to see whether our program to work. We wanted to work out the bugs. So it did have some value from that standpoint, but it wasn't that successful.

So in 2006, we did start prior authorization, same services, CT, MRI, and PET. But in this case authorization was necessary for payment. We used the same guidelines and criteria that we had established during the prior notification phase.

We've now had the program in place for over 15 months and I have some statistics up for you. These were just developed by my staff a couple of weeks ago. It's the latest information we have. And for the three sets of services, we have had approval rates of about 85 to 86 percent. We've had denial rates that have generally dropped down, starting with over 6 percent and now it's about 5.5 percent.

Withdrawals, what that means is when the doctor calls in, talks to the physician that's doing the review -- and by the way, physicians are doing the reviews. We don't use nonphysicians for the prior authorization component. If during that discussion between the ordering practice and

the physician that's doing the review, the ordering practice decides never mind, we're not going to order the test, that's considered a withdrawal.

So one of the things we've noticed is a continual drop in the withdrawal rate. And what we're thinking is that the doctors either know the system now and they've decided not to even try if the guidelines aren't met, and so they don't even bother calling.

The guidelines are available. We've made it available in both hard copy as well as on our provider portal on our website for the physicians so they know exactly what's going to be used to make the decision.

I also know from statistics that we have that I did not make available to you, but we've seen the procedures per 1,000 members drop for these three sets of services while other imaging services have stayed about the same or increased slightly. So what we think is that this prior authorization program has had an impact on these three services while not necessarily contributing to reduce utilization rates with other services. In other words, it looks like the physicians pay attention to the prior authorization and the criteria that they have to meet for

these three services and don't necessarily change their whole way of behavior while ordering tests in other fields.

Here are the percentages of change. One thing I want to note is that PET scans have increased during this whole program. I do not think that's surprising because the indications for PET scanning have increased almost monthly. Our medical policy recognizes that and the number of cancers that are now an indication for the use of PET scanning, we've increased maybe double over the last year and a half.

So that and just a general understanding of the use of PET scan by physicians, referring physicians across our state, I think has changed and it has reflected an increase in PET scanning. We still believe prior authorization has had an impact by teaching the physicians what are their appropriate indications for the PET scans, but it has not necessarily -- as you see -- shown a decrease in utilization. Just the opposite.

So in summary, we have in place now a three-phase program. Altogether we think it's pushing towards appropriate use of these imaging services rather than just concentrating on reduction of utilization. It's still

early to know whether, in fact, this is going to work. The physicians that give us feedback still complain about just the hassle factor, even though we did things to try to make their lives easier by using web-based technology for the authorization process as well as a phone process for seeking authorization. Despite that, the physicians still would prefer that utilization management not be something they have to do on a daily basis.

So with that, I'll turn it over to our next speaker.

DR. DOUGLAS: Thank you. Thank you very much for having me here and asking in general about this.

I really want to commend MedPAC for changing the debate or moving the debate on medical imaging from volume to value. I think this is where it needs to be.

My name is Pam Douglas, I've been introduced, past President of the American College of Cardiology and of the American Society of Echocardiography. I am a cardiologist, obviously, with those credentials.

What I'd like to tell you about is some of what the American College of Cardiology and the community of cardiovascular imaging providers have done in a systems

approach way to guide and enhance the provision of clinically appropriate imaging services by experienced and qualified providers.

In cardiology, as you've heard, as in a number of other specialties, imaging is very important and it's very graphically appealing. But more importantly, we have a wide range of highly effective noninvasive imaging tests to diagnose and treat disease. This ability to noninvasively view the heart and the blood vessels is critical to providing cost-effective high-quality care.

The question then becomes what are the fundamentals here. And I think we all agree in this room that quality is the number one priority, that we want to make sure that patients have access to the standard of care when it comes to imaging, as all other forms of treatment, and that imaging is provided appropriately by trained and qualified providers.

To address the quality is number one. My university, Duke, and the ACC convened a think tank 18 months ago to try to understand what quality is in imaging and understand its parameters. We came up with an algorithm that starts appropriately with the patient, goes

to test selection or patient selection for the right test, image acquisition, image interpretation, results communication, and hopefully improvement in patient care.

Each of these domains has then been the foundation for activities within the cardiology community to try to enhance the quality and imaging. For example, in the test selection area we've developed appropriateness criteria for four of the cardiovascular imaging modalities. We are now benchmarking their use out in the community and educating providers about what these criteria are and how to apply them.

In terms of image acquisition, we support mandatory lab accreditation that's done appropriately to not reduce access, as well as technologist training and certification. In the domain of image interpretation, again lab accreditation is part of that but also physician training and competency standards. In results communication we have worked out a set of key data elements that should be in every cardiovascular imaging report. We've developed templates for uniform structured reporting and timeliness standards for those reports.

And in the better patient care area, we are working on registries and on research that will help us understand the impact of quality in imaging on patient care. And this altogether looks like a fairly complicated slide, but you can see that we've taken a systematic approach to this and looked at each domain and how we can improve it.

This is what our timeline looks like within the college for the things that we're doing from appropriateness criteria, quality data elements, appropriateness evaluation pilots, data standards, performance measures, imaging registries, accreditation, continued think tank, and we will have a second think tank follow up next month to again, with stakeholders from payers, academia, industry, regulators, NIH, to try to think carefully again about imaging and implementing imaging quality. We've also done this in conjunction with all the other cardiology societies and the American College of Radiology and have enjoyed these partnerships.

To talk about the first domain, accreditation, we have looked carefully -- as you heard from Ariel -- for appropriateness criteria in SPECT MPI, in CT, and MR, and

most recently -- a month ago -- in transthoracic and transesophageal echocardiography. These sets have been done in partnership with payers as well as other cardiologists, primary care practitioners, and tried to create physician guidelines to be responsible stewards of imaging technology.

We used as a definition for appropriateness, an appropriate imaging study is one in which the expected incremental information together with clinical judgment exceed the expected negative consequences -- the negative consequences are a false negative test or a false positive test, things that you can imagine that can cause harm even though it's a noninvasive test -- that exceed those negative consequences by a sufficiently wide margin that the procedure is generally accepted for clinical care and is a reasonable approach for the clinical indication.

We have a lot of guidelines and documents in cardiology. The guidelines have been around for almost 25 or 30 years and they guide practice, and they're things that you could do. Performance indicators or performance measures that you're familiar with are generally things that you must do, that are considered nonnegotiable by and

large, things that you must do. When the appropriateness criteria are really good use/bad use things.

They're based on clinical indications, and for each modality we have upwards of 50 clinical patient scenarios that are very patient oriented and we provide explicit guidance on test frequency. We want to use these tools to prospectively affect practice patterns and resource use through provider education and knowledge as well as through tools that help provide point of care and point of service education about appropriateness.

To give you a little bit of an idea of how these play out in practice, these are some data on the SPECT MPI, 318 patients with appropriateness determined in the nuclear laboratory. They found that 82 percent of the studies were appropriate, 7 percent uncertain, and 11 percent inappropriate. Not surprisingly, the percent of normal tests, less than half of the appropriate tests were normal whereas 69 percent of the inappropriate tests were normal. And similarly, the perfusion scores, the higher the score is the more abnormal. So the appropriate scans were more frequently abnormal that the inappropriate scans. And the age predicted appropriateness, as well.

Interestingly enough, with that low level of appropriateness, 11 percent, one-third of those scans were still abnormal. So we still have a little something to learn about appropriateness criteria and how to use them and I would hate to see us say anything that's inappropriate shouldn't be paid or shouldn't be done because clearly some of those people do have cardiovascular disease and we do need to learn how to manage those patients more effectively.

We are also partnering with United HealthCare on a pilot for the SPECT criteria. This is a unique partnership that's jointly funded by our two entities. And we are providing a point of service implementation of the appropriateness criteria, a one-page paper form that's easy to fill out. There will be 10 pilot practices.

Again, this is just SPECT. Although we have the other criteria, we want to learn in a single modality first before we branch out too largely. There will be quarterly group feedback meetings where ordering providers will get information about national practice patterns as well as their own group practice patterns. We are concerned about individual feedback at this point until we make sure that

the volume of studies ordered by each individual provider is sufficient to have statistically valid information for that kind of profiling.

Importantly, we feel very strongly that more pilot programs are needed like this. And I would urge you, as a Commission, to make recommendations that would help us develop other -- not just us ACC, but help our country develop other pilot programs to implement and test appropriateness criteria in such a way that we can learn from that, improve the validity of our criteria, and help our providers practice better medicine.

There are other quality tools that we use in cardiology to ensure wise use of imaging. We are very actively involved in specialty specific laboratory accreditation and strongly recommend that this be implemented. We've fostered an inter-societal accreditation commission that accredits echo labs, nuclear labs, vascular labs, CT and MR labs in cardiology. And we feel that the specialty specific concerns are very appropriate and the right way to do this. We greatly support physician and technologist certification, training, board exams, and so on.

We also support data registries. We've had tremendous success with a national cardiovascular data registry initially started for cath/PCI which has over 5 million patient records right now and has expanded into ICDs through CMS and monitoring of that data as a condition of payment. And more recently, into carotid stenting, acute coronary syndromes, and now longitudinal patient care in the outpatient setting.

We feel that a dedicated imaging registry is needed and this is another area in which would be very interested in discussing partnership to do this.

I don't want to perseverate on the growth in imaging. This is a slide that Ariel showed. We have looked in some areas of cardiology and the most common imaging test, echocardiography, we published a paper this June identifying that the rate of growth was actually lower than that of overall cardiac services and really closely matched the number of beneficiaries as well as the burden of disease in those beneficiaries. We have to realize that as Medicare beneficiaries get older and as we are more successful in treating cardiovascular disease we have more

patients living longer with cardiovascular disease who need ongoing care.

I also wanted to mention the underuse. This is certainly something that we're very concerned about as well as overuse. It has been touched on. I want to present some data that haven't yet been published that I'm working on in conjunction with others at Duke, Kevin Schulman among them, looking at must do indications for cardiovascular imaging. There's really only one.

There is a lot of a type one class one indications, but there's only one performance measure in cardiovascular care about imaging. That's the assessment of cardiac ejection fraction or heart function at the time of the diagnosis of heart failure. This is one of only four performance measures in all of heart failure.

We used a Medicare 5 percent sample at three different time points, in '95, '99, and 2003, and looked at patients with no history of heart failure who had a new diagnosis of heart failure. This came down to a cohort of over 100,000 patients. We looked at what imaging tests they had performed 30 days before that diagnosis to two

months afterwards within the time frame that would be appropriate for satisfaction of this performance measure.

As you can see here, very small numbers of patients had catheterization in yellow, less than 10 percent. About 10 percent had assessment of ischemia or coronary disease. Structure function, in pink, is where the ejection fraction or heart function measure would fall. Interestingly enough, in '95 just under half of Medicare beneficiaries with a new diagnosis of heart failure received imaging. In 2003, we're a little bit better but not even yet 60 percent.

A higher number here of 75 percent received ECGs but overall only 15 to 20 percent of Medicare beneficiaries with a new diagnosis of heart failure -- and I might remind you that carries a diagnosis like a diagnosis of cancer -- up to 20 percent of Medicare beneficiaries had no cardiovascular diagnostic testing, not even a cardiogram. This is an underuse that I think we need to make sure that we don't exacerbate in anything that we do around appropriateness in imaging.

Interestingly enough, while 60 percent of those between the ages of 65 and 75 received ejection fraction

determinations or appropriate imaging, only one-third of those over 75 did. So we also need to make sure that we don't practice ageism in our Medicare population, as well.

We, as you've heard, eagerly pursue partnerships. The private payers have taken a route of utilization management, prior notification authorization protocols that you have heard about. In some cases, they can create delays in availability and create an administrative burden without an emphasis necessarily on education to the providers and teaching the providers about how to do it better but just saying no -- and I don't mean this personally.

We really need to make sure that we have peer-reviewed evidence that we do this. We do need to make sure that the algorithms are not black box, that they're fully understood by everybody, that they're evidence-based, that they're part of the scientific community as well as the regulatory community, and that we are looking to quality and not just cost containment because we need to make sure that beneficiaries receive the highest standard of care.

We don't want to decrease utilization because of bureaucratic hoops. We want to decrease utilization

because it's inappropriate to utilization at whatever rate is being done for whatever indication. And we don't want the messages about inappropriate use and education about inappropriate use to be lost through regulation as opposed to education and quality improvement.

We also want to make sure that our appropriateness criteria, when they're utilized, are utilized in the fall and not in a fragmented kind of way.

We also work on coalitions of stakeholders, whether they're patients or payers, as you've heard about. We have worked with over eight of the state local carriers to develop imaging programs. We've worked with physicians in cardiology, outside of cardiology, with radiology. We're very pleased about that.

We have a Medical Directors Institute which is now in its sixth year, which meets with medical directors of private payers and CMS, as well, to dialogue about how we can improve cardiovascular care in all areas not just in imaging. But the appropriateness criteria effort is an important product of that dialogue and of that partnership that we're very pleased with.

We're pleased that other quality organizations such as the Ambulatory Quality Association are adopting things like our appropriateness criteria for implementation or recommendation for implementation in their arenas.

But we also need more collaborators and we need to identify and test more real-world solutions.

In summary, we need to pay attention to both volume and to value. We need to make sure that we address the growth in imaging through quality improvement and not only through limiting the numbers arbitrarily, the numbers of images. It needs to be strongly addressed so that we responsibly provide health care but also responsible use of dollars. And, we need to exercise caution not to exacerbate underuse such as what I've showed you.

We feel that we've been a proactive leader in imaging quality and our systems approach has produced a comprehensive way of standards, initiatives and real-world implementation solutions to problems of appropriateness. We've also developed stakeholder partnerships that are incredibly valuable to us and I think the medical community as we go forward to try to find answers in this difficult arena.

We'd like to expand those partnerships and initiatives with CMS and with others as again, in particular, examples of how we might do that, appropriateness criteria, pilots, and an imaging registry.

Thank you very much for listening and for the opportunity to appear before you.

DR. COURNEYA: While this is coming up, I'd like to thank you, as well, for the opportunity to present some information from the work that we've done in Minnesota on diagnostic imaging.

I come from HealthPartners which is actually the largest cooperative organization in the United States. It's a member-governed organization. It has 700,000 members that are covered. We have a medical group with 600 physicians. We have a hospital and we have a research foundation, as well as an Institute for Medical Education that is responsible for residency and allied health training work that gets done.

That leaves us no place to hide. Essentially all of the impacts that occur as a consequence of paying attention to this issue fall on our shoulders as well, regardless. So some of the things that we do as a health

plan may actually create problems for us as a provider group. But we feel we've found ways to negotiate through a lot of that, in this arena in particular.

What I'd like to do today is first of all set context, a little bit more background information about our particular circumstances, talk a little bit about the program goals as they developed over the last two and a half years, go through a brief program description, and then talk about some of the preliminary results that we have. We just started our program this year, February as matter-of-fact. And then also, to talk a little bit about some of the lessons learned and future directions that we see for our program.

As others have said already today, there's rapid growth. Our experience is no different than anyone else's. For the last several years overall diagnostic imaging has grown rapidly and for high-tech imaging in particular at 20 plus percent rates.

One of the things we realized too is we really have no good data on appropriateness in our market. It really complicated our conversation because while we could point to experience in other markets, it's quite easy for

us to believe that our market is different than everybody else's and so dismiss the trend as something that's appropriate here but not elsewhere.

We did have, however, that significant impact that we saw in other markets from utilization management strategies and we really couldn't ignore that as a health plan and even as a medical group, recognizing that quality improvement inevitably arises or can arise from greater scrutiny on this kind of an issue.

Another important part of the context for us in Minnesota is that we do have a high percentage of large medical groups in our market. In fact, five medical groups in our market probably care for more than 50 percent of our patients. That leaves us with an opportunity to have conversations that can have a broad impact with a relatively small group of providers.

Also, we have a well-established, well-respected quality improvement collaborative in the Institute for Clinical Systems Improvement that is subsidized, it's underwritten by the health plans in the state. And we have a membership that actually exceeds the Minnesota Medical

Association membership as far as the number of physicians who are affiliated with ICSI.

Also, there's been more than two years of conversation with medical leaders, health plan leaders, employers, state, and also our membership.

Another aspect of the context that's really important to consider is we have a high penetration of automated medical records. In fact, by the end of the year more than 70 percent of our membership will be going to clinics that either have fully implemented or have actually begun implementation of automated medical records.

We have seen in Massachusetts, in particular, early success with decision support at the point of care for diagnostic imaging. Mass General and Partners HealthCare, in response to utilization management programs in the early 2000s, developed their own automated decision support. That really created some improvement that was similar to what was going on with utilization management programs and gave us confidence that we could forge ahead with the idea in our marketplace.

The other thing that was important was that our medical group was willing to program and test that concept

and that set a competitive context that the other medical groups were not only kind of motivated to respond to but pretty well equipped to respond to as well.

Our medical group gave away its software to any of the other users in our market that used the same platform for automated medical record. That particular automated medical record has deep penetration in our market so it had a real significant impact, as well.

Of course, our program is intended to manage trend and we've been up front on that in our conversations with all the provider groups and everybody that we talk to. But we also see a real opportunity to improve the quality of high-tech imaging orders. The pathway of components that you just described, we laid out a very similar pathway and we saw at each step along the way basically raw materials. The clinical circumstance is the raw material that turns into the decision about whether or not to go ahead with diagnostic imaging, that turns into the image itself, that turns into the interpretation, that turns into the clinical decision about the patient circumstances. At each step along the way the higher quality the raw materials, the better the outcome is going to be. We saw

decision support at the point of care as a real opportunity to improve the quality of that first step in the decision process.

We also want to improve communication between ordering and rendering providers. We want to set up a circumstance where rendering providers are not just order fulfillment places. They are actually more participating in the clinical exchange of information. By virtue of this process, the ordering embeds the clinical circumstances in the order itself, so that the rendering provider, the radiologist, has more information as they create image and interpret it.

We also want to improve and increase provider accountability for appropriate ordering and that accountability is based on data and the willingness to be transparent about that data.

From the perspective of our consumers and our members, we really want to be able to provide better cost and quality information for them. There's two ways that we can do that. We can do that as a health plan by providing it on our website. We can also do it by improving the amount of information that's available to the patient in

the context of the exchange between the provider and the patient at the point of care. That's one of the things that we get out of decision support at the point of care.

We also wanted to gain benefit. Internet is obviously a very important tool. And because of what I alluded to before, we have a large installed base of automated medical records. We really saw this as an opportunity for one of the first broad applications of decision support in a way that was meaningful both in terms of quality and in cost.

We also were strenuous in our work to try to minimize patient care and workflow disruption at the point of care, both in terms of the program that we've presented and also in our willingness to offer the option for provider groups to develop their own.

We also, in that context, accepted the idea that there would be innovative alternatives that promised to achieve those same goals, assuming that they were structured with certain criteria at the outset.

In that context, we decided to go in the direction of decision support through prior notification not prior authorization. Now we did have a hook in there

because we would deny payment to provider liability if there was no engagement in the prior notification process. We didn't do any denials but if you didn't participate, the rendering provider didn't get paid. That, of course, created some consternation but it also made rendering providers an ally in assuring compliance and participation in the program.

We did partner with American Imaging Management to provide support with this and we do include MRI, CT, PET scans, and nuclear cardiology. Of course, what we're talking about is comparing clinical information to guidelines based on the ACR and ACC criteria, among others, vetted by physicians looking through them and vetted by our own local provider groups, as well. and then giving immediate feedback on appropriateness to the provider, whether that's in the context of decision support within an automated record or in the context of decision support using American Imaging Management through the Internet, by Web or by telephone.

Now our program, as I've said, allows the build-your-own option. It has specific design criteria and reporting criteria. It includes all the same scan types as

in the AIM program. It initially required decision support content for the top 90 percent of the scans by volume, which is exactly the same 90 percent if you calculate it based on cost. What it did is it gave provider groups who were developing their own process the opportunity to focus on those things that had the highest impact and over time to develop the content, the clinical contact for the decision support for that small number of scans that account for the last 10 percent.

We also required daily data submission. Because there was a denial to provider liability for the rendering providers, the rendering providers really needed the opportunity to look on the website and see that the process had been completed for those who did the build-your-own. One of the real accomplishments was the fact that in Minnesota all of the health plans and all of the provider groups participating were able to agree on a minimum dataset that they used for all the different programs regardless of the payer.

We also get monthly detail, will be getting monthly detail, from the providers who have the build-your-own that allows the opportunity for accountability down to

the clinic level. But our criteria require that the providers are able to look at it down to the provider level and to use that internally for quality improvement and education purposes.

With your materials is a set of those design criteria so you can look at those in greater detail. In fact, I think it illustrates the collaborative nature of the process that resulted in those. I think at one point it says this was suggested by Brian or one of the physician leaders in one of the medical groups. There was a real extended give and take and exchange of the information and it sets up design criteria that all of the health plans are willing to accept based on their individual conversations with the provider groups who are building them.

As I said, all of the regional health plans in our market agreed to accept this is alternative but, of course, the relationship between the health plans and the provider is based on conversations that they have individually, not based on that collaborative. We, as a health plan, issue no denials in either version of the program, whether it's build-your-own or the American Imaging Management program that we have.

We do rely heavily on the Institute for Clinical Systems Improvement collaborative to facilitate those discussions and lay the framework for that build-your-own option. It also is a very important forum for us to have conversations moving forward as we refine the program.

Phase two of the program will actually require quality information from all the freestanding rendering providers, as well. That fills that gap that Ariel alluded to where the hospitals and the hospital affiliated rendering providers have requirements but the freestanding ones don't.

We've had actually some really favorable results. Now there's a caveat. This is based on first quarter performance and first quarter this year was a partial implementation because we didn't begin until February. We had actually projected prior to implementation that we would be getting 200 to 250 contacts per week in the first quarter with a ramp up to about 450 in the second quarter but actually did much better than that. Those projections were based on a forward trending of what our utilization was at the time we put the program in place.

We actually got 504 contacts per week in the first quarter, rising to 628 in the second quarter. The feedback that we got from the provider groups, one important thing to realize is that this is just those contacts that were through American Imaging Management. It does not include the decision support programs because that reporting is done by a different process. But we were told that the ease of the web-based option and high service level were important success factors.

Turnaround time was important. And we moved very quickly to a 50/50 ratio between those using the Web and those using telephone because as soon as they found out exactly how to use the web and we clarified that for them, they found it much easier.

We were also actually very gratified at a much higher adoption of the build-your-own option than we expected. We had projected that by year's end we would have five medical groups touching roughly one-third of our membership. But we do expect 17 medical groups by year end, touching over half of our membership.

We've evolved from including just ordering providers to ordering and rendering providers. That was

the result of a sensitivity to the fact that if you don't have an automated medical record you're kind of closed out from that option.

We set the same expectations about provider level and group level reporting from the rendering providers and so we will get the same kind of performance information that we do from the ordering providers. It sets the expectation that the ordering process requires them to go through a decision support process, and also that same kind of daily data reporting for closing the transaction loop.

It's important to realize that some built the program, some bought it. And actually in our marketplace HealthPartners Medical Group built the decision support tool and then gave it out so that those outside of HealthPartners Medical Group who did not purchase actually received it from HealthPartners. And in collaboration, the regional users group for the program is actually working to try to support and maintain that content.

We've had high guideline compliance for our AIM program, which is where we have the most detailed information. 57 percent in the early going have passed the review immediately. 33 percent -- and that's based on the

information provided over the Internet that's screened up against the criteria -- 33 percent were cleared by RN level review and more information was necessary. About 10 percent require peer-to-peer review. After going through the whole process, 92.5 percent of the scans performed met guidelines, 1.5 percent were withdrawn. And of course, no denials, as I said before.

With regards to trend impact, and I'll clarify some of the reasons we believe there is a significant difference in the categories. This is based on that first quarter with a partial implementation. This is not annualized, this is the actual savings for that quarter. In our commercial population it was 50 cents PMPM, self-insured 46 cents PMPM, which I think reflects the fact that at least in our marketplace the systems approach to care makes it very difficult to treat different people differently based on whether they're commercial or self-insured or any of the others.

Now there is a difference though in the Medicare risk population and the Medicaid population. Medicare risk, we think partly that's a consequence of the fact that our Medicare risk population is pretty small. So it's

vulnerable to small number variation. With the Medicaid population we think that's because a substantial proportion of our Medicaid population is cared for within our own medical group. As of February 1st, they were up and running with their decision support process being applied consistently across all of the population. So that had a skewed impact on the Medicaid population and resulted in improvements that were more rapid than the other populations that we recover.

There's also been a trend change in procedures per 1,000 members; commercial a drop of 11 scans per 1,000 compared to last year; self-insured seven scans per 1,000. Our Medicare risk population 38 scans, again small numbers variation is in an issue here. And Medicaid dropped by 26 scans per 1,000.

With regards to lessons learned, and these are some of my subjective lessons learned. And they're based on the nature of that collaboration and what we had to do in that collaboration to succeed. First of all, being up front about transparency and cost and quality concerns actually helped prevent reactions from others derailing the program. Partly that was because we already had

collaborative conversations going on even before we announced the fact that we were going to put something in place. So lines of communication were opened. And even where there was tension between parties, communication did not break off.

Minnesota Medical Association actually did introduce some legislation calling for a moratorium on any utilization management for diagnostic imaging. However, I think because of conversations with the Legislature and the fact that all of these parties had recognized that this was an issue that needed attention a moratorium was not called for them. A study group was but was not funded. That's a convenient way for that to work out.

Minnesota Hospital Association was actually a very gratifying conversation. Our relationship with the Minnesota Hospital Association, as you might imagine, has been contentious at times. But in this context, because we offered the opportunity even for their constituents to a pathway to a build-your-own solution, it worked really quite well. We participated in forums both over the phone, on the Internet, and around the state to have conversations about how to create that pathway. And they actually have

one now that they're going to be offering to their constituent organizations.

Legislative conversations, both in terms of our state employees and the government programs. They were also grappling this problem, and we had had up front conversations about this and so our legislative conversations were really quite productive.

Public, we've had 22 complaints that required any service recovery so far in the program. We have had a higher volume of telephone calls but they're mainly to clarify what is and isn't required for the program and those are beginning to trend down now.

The other thing that was an important aspect of this was that the ICSI collaborative was a key to success on this and there are other groups that we've worked with that have helped this along.

Our experience is that prior notification, when it's tied to denial of provider payment, does have a significant impact without denials being a part of the process. Strenuous efforts to reach out to providers, to collaborate, and to minimize clinic workflow disruption eased that implementation. We have seen some innovative

collaboration between traditional adversaries in our market.

Local knowledge of players was critical and that was part of that collaborative conversation. There were many steps along the way where the conversations were quite tense but everybody stayed at the table and was will to go through those difficult conversations to get a solution.

Setting design criteria for the build-your-own solution was critical for the provider groups because it gave them the confidence that they could move ahead with their own projects knowing that they would beat expectations for the different payers in the market and they could use one workflow and one set of criteria and consistently deliver the care to all of their patients.

In its early phases, we don't know the full impact, but clearly decision support is preferred by the providers. I'm still in practice, and in our practice providers come up to me and they compliment us on having the flexibility to do this and the ease that they incorporated into the workflow.

Another important part of this is that flexibility requires a lot of extra work. Our team on the

health plan side has had to do a great deal of extra work to make sure that those collaborations work smoothly. Working out the data exchange issues has been remarkably challenging, certainly more than I would have ever expected from my perspective as a physician. But in spite of that challenge it has been possible to do it and we're moving ahead and exchanging data really quite effectively in the early phases.

Future directions will include grappling with the problem of content maintenance in our region, especially for those who are doing the build-your-own. They recognize that maintaining that content is a real challenge and we are working towards a pathway to a broad solution for Minnesota for that kind of content maintenance.

We have actually, through our research foundation, funded a retrospective chart review to get a sense of whether or not that's a viable tool, to get baseline information so that we can correlate that baseline information with outcomes. And in the future what we hope to do is to be able to look at the impact on clinical outcomes and correlate relative efficiency in the use of these high-tech imaging and whether or not they are

threshold beyond which you begin to see a deterioration in the quality of outcomes. All of that will be moved forward in the context of the ICSI collaborative so we will have input from -- and we're looking to expand the membership of that ICSI collaborative around diagnostic imaging to include members and payers as well, plan sponsors as well.

That concludes my comments and I really appreciate the opportunity to tell a little bit about our program.

MR. HACKBARTH: Those were terrific presentations. In fact, so terrific that I've got enough questions here that the rest of the Commissioners can go on break and we'll just have a nice conversation.

Let me begin with just one question, and this is for Dr. Douglas. You are absolutely right, the goal here needs to be to pursue high value and make sure that we don't, in our haste to try to slow the growth of expenditures, do real damage to patient care. We've tried to do that to this point in our recommendations. I think some people think we've been maybe too timid as a result in what we've proposed. But we really recognize how complicated this task is.

What I wanted to ask about is your effort to develop appropriateness criteria. As I interpret the appropriateness definition that you showed in one of your slides, it treats the test as free from a financial standpoint. So if there's any incremental benefit that outweighs the risk, it's appropriate care.

And I don't mean that as a criticism. That's the environment in which you operate. That's the ethos of the American health care system. Am I interpreting the definition correctly?

DR. DOUGLAS: That is not quite true, although close. What we have done is the process of creation of this is that we spend four to six months creating the clinical scenarios and then we convene a technical panel which meets face-to-face for a day or a day and a half to discuss the indications, modify them, and rank them. And then they go home and then they rerank them again. So there's a second ranking process before the paper is written. They take between nine and 15 months to generate each one of the criteria.

The technical panel actually is actually what creates the numbers, the scores. And they're instructed to

implicitly consider cost but not explicitly consider costs. In other words, they're not sitting there adding up how much it costs to go this pathway or how much is that pathway, but to implicitly consider it.

We initially started exactly where you said, don't worry about cost, let's just think about clinical considerations without realistic health care considerations. And people were simply unable to do it. They just said I can't separate these out. This is a utilization issue. There are clinical components of it, there are economic components of it. So we said we're not in the business of doing detailed cost effectiveness evaluations but you all know what things cost and we can't take that out of your brain when you make these kinds of rankings.

MR. HACKBARTH: Let me just pursue that one step further. I'm just trying to get a sense of how this works in the real world. Assume there's a test that can improve the likelihood of an accurate diagnosis and appropriate treatment from 90 percent to 95 percent and it costs $600 or $700. How does that weigh out?

DR. DOUGLAS: It would probably be inappropriate. And if you look at our stress echo and stress nuclear -- stress echo isn't quite out yet, but stress nuclear is out. And when you have intermediate pretest probability folks with good ECGs and they're able to exercise, it's either inappropriate or uncertain, it's not appropriate. So the push is to say that your routine stress ECG without additional imaging is preferred in those cases and that you don't need the incremental predictive value that you get from an imaging component associated with the incremental cost.

MR. HACKBARTH: I'd love to be able to further understand exactly how that works.

DR. REISCHAUER: It must be something in the Washington water because that was the first question I was going to ask you, too.

But if you don't do it explicitly and so each individual involved in this is sort of weighing it in their own way, and the cost of these things is changing rapidly year to year, how do you really end up with something that has consistency, that had predictability over time?

I'm not suggesting that maybe you and your group should be the ones doing this because in a sense it's those of us who impose budget constraints and draw the lines that maybe we should. But I'm a little nervous about everybody considering it in their own way.

DR. DOUGLAS: Your point is very well taken, both of you. If you're really going to parse out what the considerations are when you're facing an individual patient, I have a patient that comes in with chest pain. I could get one test today or I could wait three weeks for a better test. Well, maybe I really do want to know today, even if it's not as good and perfect information that I might get in three weeks.

Or if the provider of that is not as skilled as the provider or has the expertise, I think as some other person that I might refer them to. There's a lot of very pragmatic considerations through there and it's almost impossible to weigh those things.

In some places, the actual cost within a health system, as you well know, varies tremendously for the same test. And so to set an appropriateness criteria that

explicitly considers costs, it would have to be a different level of appropriateness here than there.

I do want to say that one of the things that we did do was ask two completely different technical panels to rate the same 20 indications to see what the consistency was across those indications. And I'll say unfortunately because it's almost too good to be true, it was exactly the same. And I don't just mean within the category of appropriate, uncertain, and inappropriate. I mean the actual number. All of those ended up exactly the same, and these were two 15-expert panels that we convened.

So there's some validity to the methodology.

DR. CASTELLANOS: I really appreciate what you've done. I happen to be a clinician so my questions are going to be a little bit more practical rather than theory.

Ariel, I think you really presented the material nicely and we certainly appreciate the three of you being here.

I think we all agree that we want to provide the highest quality. We want to try to be as cost-effective as we can. And we want to try to be as appropriate as we can. One of the things I really liked, Dr. Douglas, when you

presented, your algorithm starts with the patient. I think that's really, as a clinician, my focus is on the patient and taking care of the patient. I really appreciate your algorithm starting with the patient.

You said the approach, you looked at the study and you looked at the sensitivity and the effectiveness of the study but you said also the clinical judgment was very important. I don't think we're having a turf -- yes, we're having a turf battle. I'm not sure if it's silos or how you want to put it. But we all need to kind of work together and not separately.

I personally think that the American College of Cardiology has done a great job and probably are the leaders in setting the standards and the guidelines on how to approach imaging. I would hope that every other society does it.

My only point here is I think the American Radiology Association has done a good job. And they have collaborated with a other folks, and I'm not saying they don't. But a lot of the decisions are clinical, are face-to-face with the patient. And I'm saying to you that the

radiologist doesn't have that experience, and I think the clinician does.

So I think the guidelines need to be worked together, not as a silo but together with the radiology groups and with all the other partners taking care of these patients. I think that's important and I think we're not getting in a turf battle on it, but there's been some concerns, especially in the different societies, on that point.

You know, there's a lot of different ways of controlling things. One is from the top down, and one is from the bottom up. I think, as you did, with consensus among the cardiologists or consensus among the orthopedic doctors, you're going to do a lot better than coming from the top down. I'm not saying that the radiology benefit management companies don't do a good job because obviously the data shows they do a good job.

I guess, Dr. Vinson, the one question I have on you is by denials, and I'm going to ask you to answer that later, but can you specify is it by specialties or primary care? Is it within the specialty? Is it specialties that

don't have the algorithms that cardiology has? I think that's important.

I think the other question I have with you, and it's a very practical question, and it's a concern among physicians, is how do RBMs get paid? Is it like the RAC, which gets paid by a percentage of how much they recover in denials? That's a question that I have.

Pam, I thought your question on underuse was very appropriate because we really are focusing a lot on overuse but underuse is an issue also.

I think physicians do respond, as we saw in your data with underuse. There is some improvement. Ariel, you stress mammograms as a big underuse. If you look at the data from 2006 that just came out, we've had an increase of 60 percent use of mammograms. That's the data from the AMA. I didn't say we were up to where we should be. I didn't say that at all. But I think physicians will respond appropriately if given the right data. I really appreciate you bringing that underuse up.

Dr. Courneya, I think your point about there's no good data for appropriateness is very, very apparent because there isn't any. We don't have any credible

organization now. There's a push by MedPAC and others to start up a comparative effectiveness group. And I think until we have appropriate data we need to depend on the clinical clinicians, the experts in the field in combination with the radiologists. And I say we need to depend on each society.

I thought it was very appropriate that you don't have any denials but you address the prior notification which I think is appropriate because it doesn't impact on the patient. I think that's a very appropriate way of doing it, and not by prior authorization.

But again, I thought you all brought up a lot of good, good points.

My last point is a point is that MedPAC is also interested about cost. I know last spring we were talking about practice expense. One of the issues there was that there were a lot of policies put in place. And I know Dr. Borman and myself said hey, let's see what the policies do before we start making more policies. Well, if you look at the data between 2005 and 2006, in 2005 we went up 21 percent in costs. In 2006 it and went down to 7 percent.

That's a significant change by policy. I think that's appropriate.

Thank you.

MR. HACKBARTH: Why don't you each take a shot at some of the questions.

DR. VINSON: The questions that came to me had to do, first of all, of how was our vendor paid? They're paid a flat rate. They're not paid by the rate of denials. We decided early that that was not appropriate, that they were doing work for us working on appropriateness, and that's all of those reviewers. They are bringing expertise in discussions with the referring physician, referring practitioner. That's how we felt they should be paid.

In terms of denial rates, we are trying to break out what type of specialties, what type of denial rates. Early results are that, first of all, that 85 or 86 percent approval rate you saw applied across all referring physicians. It wasn't broken out by specialties.

The primary care physicians tend to have a higher denial rate than the specialists. Maybe two to one or three to one. One of the things we're trying to do now is with enough information is to go back and start taking out

specialties or physicians and practices that have zero or 1 percent denial rates. They've proven that they follow guidelines. There's really no reason to continue to follow them. It's a harder technical process than maybe you can imagine but we're trying to do that for that reason.

Among the PCPs, what we discovered -- and it relates to your question about appropriateness. The most common denial we had in the first six to nine months were for primary care physicians ordering CT scans after a patient came in with abdominal pain. They were ordering a CT of the upper abdomen, a CT of the lower abdomen, a CT of the chest, and a CT of the pelvis. That happened repeatedly, thousands of times.

And when we tried to understand why did they feel like they had to get four for separate CT scans, which were all paid separately, so we've quadrupled the cost, we went back and tried to understand why they did this. It turns out there are no appropriateness guidelines as to exactly how to order a CT scans of the abdomen in the presence of abdominal pain. ACR didn't have it. ACR didn't even have a definition of exactly what anatomical cutoff was involved with CT of the chest versus CT of the pelvis.

Our medical policy didn't address it either. So how would the primary care physicians understand exactly? So they just assumed that you had to order all four. We did find some articles, not based on evidence, where the writer suggested getting all four, just in case.

So that's an issue I could not address it, although we ended up deciding to deny two out of four. Again, that may be too liberal. But we decided that in the lack of clear understanding of exactly how order the test, we would give in some and try to accommodate as much as possible.

But that was a frequent ordering that we found only after we started doing this program. And it is not something that's easily addressed by the literature. I think that's an example of where we hope that this process will give feedback to the primary care physicians. But they're the ones who have had the most trouble ordering these advanced tests.

DR. COURNEYA: I had a couple of comments. First, just to tell a story about underuse and what we were able to do when the recent recommendations for MR screening mammography of women at high risk came out a few month ago.

Because of the conversations that we had had, because there was at this point already a substantial installed base of decision support in the medical records in our community, we were really pretty quickly able to come to agreement on using those standards in our community and then broadly distribute those standards to the point of care. So it allowed us to really quite quickly ramp up, as opposed to having the inevitable period of confusion between the promulgation of a guideline or a recommendation and the broad adoption of that recommendation. So in our community very quickly that happened and we were able to use that information to improve the standard of care immediately.

The other thing is that the data that we're gathering as a consequence, particularly since we have plans and provider groups around the table, we are constructing a platform for getting at some of those difficult questions about appropriateness and outcome and whether there is a relationship between increased utilization and differences in outcomes and differences in decisions.

So while it was challenging and it arose as a consequence of cost, we see it really as a platform for answering some very important questions in an area of health care that's expanding rapidly. Our radiologists say that these capabilities are on the verge of exploding and if we don't manage these in an effective way and understand our use of them, we wind up in real trouble.

There's another point I'd like to make about getting the specialists involved in this process. I think the lesson has been learned actually at Mass General, and I wouldn't want to press this point too much. But what they have found is within specialty groups they did find individual providers who were outside the norm for reasons that didn't make sense clinically. But they also found that these providers were the ones who adapted most rapidly to new information. And it served as an opportunity to see that spike in utilization that's appropriate and distribute it rapidly among the rest of the group so that the information was distributed much more rapidly than it would have otherwise.

So I would hate to miss the opportunity to use that expertise as a part of the data that we use to make

improvements in the quality and address that underutilization issue.

I guess that's the comments I'd like to make on the issues.

DR. DOUGLAS: A couple of comments. First of all, thank you for noticing that it starts with the patient. It also ends with the patient, which is where we feel it should end, and the need to communicate clearly to the provider that's going to put the findings into context is really critical importance of quality.

You touched on turf. In fact, I don't feel that there's turf on quality. As a matter of fact, I feel that the quality, or our experience at least in the cardiology community, is that when we're able to start talking about quality we all become friends.

The algorithm that I showed you, the ACR was there at that meeting and the ACR endorsed our philosophy and framework around imaging quality and has been a very valued partner through the development of all of our appropriateness criteria. And it's given us a way actually to come together around quality. When we're fighting about volume and who gets to do the test, it becomes a little bit

dicier. But when we can look at the high road and look at what we're really all aiming for, it takes barriers away rather than building barriers.

I would like to just sort of say to you, the question of where the denials are coming from, what we're finding with the appropriateness criteria is that there is a slightly higher rate of inappropriate indications for nuclear cardiology ordering from primary care physicians than from cardiologists, although we haven't balanced that with the prevalence of disease in the two patient panels. In other words, cardiologists are more likely to have patients with cardiology diseases and so need scans more than primary care practitioners.

DR. MILSTEIN: A couple of brief comments and then two questions.

The first comment is listening to this, I kept thinking what a very valuable medical education function all three of your organizations are serving and reflecting on whether perhaps some of our Medicare medical education dollars should be more widely distributed.

A second comment is listening to all three presentations, and especially on the kind of percentage

impact you've had so far, I sort of reflected on the disjuncture between what kind of progress you've made and the IOM report commenting that current evidence suggests that 30 to 40 percent of American health care spending is what should be regarded as waste. There's obviously some pretty big disjunctures between the kind of opportunity for improvement you're funding and that 30 to 40 percent number. I began to think about what questions I might ask you to help me understand that disjuncture.

The first question is I remember when RAND did some of the more fundamental research on appropriateness 15 years ago, one of their, I thought, wonderful insights was that since in most of this area you have to function in the gray area where evidence is not crisp and you're relying on clinical judgment, that when they added to their appropriateness panels a majority of physicians who were not in the clinical area that were economically benefitting from the criteria, the criteria changed quite a bit and the inappropriate rates went up quite a bit. I would be interested in your experience or comments as to whether or not the same relationships might occur if there was more use of physicians outside the specialty area within which

judgment based appropriateness criteria were being developed.

The second question relates to I think when the IOM is talking about a 30 to 40 percent waste in health care spending, part of it has to do with overuse or what Elliott Fisher would refer to as supply sensitive services. We don't have good criteria, but in some areas there are a lot fewer of them provided and with evidence of no negative impact on quality.

But some of that 30 to 40 percent the IOM is talking about is simply in wasteful production methods. In other words, unnecessarily high unit cost per image produced.

The second question is what are your thoughts as to what can be done to not only engage the profession on using these tests more appropriately but learning how to manufacture them more economically so when we at Medicare do our evaluation as to how much we could pay for services, that the results could be based on a profession that is striving to learn how to produce these images more economically?

DR. COURNEYA: When I alluded to the fact that one of the models we started out with was starting with the patient and their clinical circumstance and the first clinical decision to make an imaging decision, what we thought of was that at each step along the way there was a transfer of raw materials into another value add vendor. And they can decouple themselves. In fact, now diagnostic imaging is data packets and that frees up some aspects of the economics involved. So I think that there may be some opportunities there.

Transparency about cost is important.

And also, as I talked about before, being able to create the platform for looking at whether or not there is value in terms of outcomes and efficiency of coming to an appropriate clinical decision is another place. And once you've got that transparency, once you've got freedom of movement of information or raw materials to different places, you do have an environment that's much more likely to produce a result that's typical of the rest of our economy and not of the health care system.

DR. VINSON: I heard two questions, so let me make sure I heard correctly. I think the first one had to

do with what I hear all the time about the self-referral issue; is that correct? I mean the idea that if the provider of the image is the same as the referring provider for the image?

DR. MILSTEIN: Maybe I can clarify. My question relates to whether we're talking about the imaging benefits manager you're using or independent panels putting together appropriateness criteria in the absence of evidence, which is what we're primarily stuck with absent more investment on outcomes research.

The wisdom and I'll call it the experience that certainly RAND found helpful of making sure that when you're coming up on those criteria those appropriateness criteria are not primarily determined by panels composed of the specialty that will benefit economically from those criteria.

DR. VINSON: Thank you for that clarification.

We took ACR's recommendations. Yes, it was especially that specialties' viewpoint. And it was, in some ways, skewed toward the idea that the provider would know best when the test was indicated. We modified those guidelines in response to our other panel of physician

advisers that were overwhelmingly made up of referring physician community for that reason.

But it is looser, I guess I could say. Most of the feedback we received from that panel was not based on study or evidence. A lot of it had to do with their anecdotal personal experience. We accepted that. In the end we felt that was still important for clinical care, even though we could not necessarily point to sensitivity, specificity, predictive value studies.

So it was something we just recognized was a facet of appropriateness, is the way it was defined in the community at that time. I think that is something that needs to be worked on more. The example I gave about the CT scans of the abdomen, I think is an example of where it would be great if the gastroenterologists had similar input on when those tests were appropriate. ACC has done a much better job. I think their ahead in this area on that type of focus. We need it. It's not there yet.

Then your question about the economics of the manufacturing, in other words trying to reduce just the waste within the provision of the service. We've looked at that. We've known that we get very few new providers

asking to perform mammography because the margin on mammography is very small. At the same time we get hundreds of requests to do MRI, open unit MRIs. We must get a request every day to start a new one. So obviously the margin there is much better.

So we've tried to look at that but, as was mentioned before I think by Ariel, the manufacturers have been very cagey. They've dropped the cost without necessarily telling us, as we're trying to calculate reimbursement. It's something that changes monthly and we don't know exactly what the cost is. We've worked with providers but in the end it becomes a matter of us trying to come up with a reimbursement decision that keeps enough of the service in the community. We don't want to drive anyone away.

So I think that's, again, a gap in our knowledge of what really is going on out there and is there a way that we can improve that efficiency.

DR. DOUGLAS: A couple of comments, one on the modality experts, is what we call them, within our cardiology imaging panels. We have always had the technical panels be less than 50 percent modality experts

and have always included primary care physicians and payers on the panel so that we have a very broad perspective on that. So we have addressed that.

We are in the process of comparing the score with expertise. What we're having trouble doing is figuring out who is an expert. I mean, are you an expert if you read nuclear scan two hours a week, four hours a week, six hours a week, 20 hours a week? It's very hard to know what an expert is.

And we're going to try to see if we can see significant differences in the level of appropriateness based on amount of time you spend in interpreting that particular modality or whether you took an advanced exam in that modality, or whatever it is. Stay tuned on that, we're working on that one. I think it's a good question. But we have erred on the side of fewer experts than generalists.

In terms of the cost, I think there's great incentive on the part of the providers to have as large a margin as they possibly can. So my guess is that most providers are trying to be as efficient. The reimbursement

and how that relates to that is obviously another story because there's a little bit of a disconnect.

I think one avenue to this is the accreditation process because the accreditation organizations are looking at processes and procedures in labs and they're setting standards for that and they're sitting standards for things that should be done. But they can also set standards for things that don't necessarily need to be done, or how long an exam should be, or how long it should take.

And collaboration and partnership with the accrediting organization will be a very valuable way to get at that within the technical component of the image performance part.

DR. COURNEYA: One other point about the issue of the specialty society with the self-interest in the outcome of the guidelines that they promulgate.

First of all, having structures that include a broad membership is important. I think the other thing that's important to recognize about this area in particular, and actually all of medicine, when the scrutiny and conversation occurs and transparency is a part of that both in terms of who's on the panels and what the results

are, and you do have processes locally that provide another level of vetting, you're not getting to the best place right away. But you're beginning to get there. In a place where there is absolutely no sense of what the right thing to do in a lot of cases, you're really trying to get closer to what's right. It's like the scientific process is not necessarily moving towards truth, just away from ignorance. So that's important.

MR. HACKBARTH: Okay, we have about 20 or 25 minutes left and I've got at least five people on my list. So we're going to have to ration questions.

DR. REISCHAUER: Only appropriate ones.

MR. HACKBARTH: Only appropriate ones, and there's one arbiter of appropriateness.

MS. HANSEN: I'm Jennie Chin Hansen. I probably bring the perspective of really the consumer parts, and so I'll be asking one question.

But one comment about it, relative to your last statement, Dr. Courneya, is this whole thing of culture change. I think what you've done is by developing your own and then just giving it out freely and the ability to have that kind of experience of change in the entire community

and not just a proprietary aspect, to me is a significant part of community. And the same thing about bringing together multiple stakeholders.

My one question is relative to the kind of information that's been developed. I hear you providing cost and quality information to your consumers and in what form do you feel that has affected the fact that you've only had to date 22 complaints really brought up. Is this the consumer stakeholder -- I saw the patient at the beginning and the end. But what role does the public in some ways have in participating, being both informed and using the information with accountability in the future have?

And that ties to me, just so that you know, I also am very concerned about the copays, the Part B side impact on the Medicare population.

DR. COURNEYA: A couple of comments on that. First of all, it's communicating in as many different ways as you possibly can because different patients, different consumers will have different ways to access that information.

The other is making sure that the information is available to them at a time when it's meaningful to them, when it can have an impact on their decision. That's one of the reasons why having information, in this case about appropriateness, in the exam room as the doctor is having the conversation with the patient is very important.

In fact, I've had conversations where patients come to me really expecting a scan. And I'm able to look at the criteria and say I know you came in thinking that that might be a part of this. But here's why you don't need it. And here are the things that you should watch for that will tell you when you do need it. And giving them that information was very powerful. They leave my office happy with the information and knowing what they can do next.

So providing information at the time when it's in the context of a relationship that's most valuable to the patient is important.

MS. HANSEN: [Inaudible.]

DR. COURNEYA: Yes, that's possible sure. In fact, what we do is in our context we have a visit summary that they leave with that includes the specific

instructions about those things. In the case that I'm thinking about, that's what I did, I listed those symptoms that I would want them to watch for.

So it really is having transparency kind of at all levels where the patient may interact with the system, having that available on your website. We're looking at actually, and we've engaged our member council to give us feedback on member engagement strategies that they would find positive. One example is a patient who had been through cancer and had many scans. She said she would value having information about where she could go to get the most cost effective one because she had a substantial copay. She said I could save hundreds of dollars every year if I know that just going down the street I could get a better value.

When you combine that with a process that assures that those are accredited sites, you can give them confidence that they're making good decisions. So there are a lot of opportunities I think and we haven't explored them as fully as we should.

DR. VINSON: We announced this program over a year ahead of time in all of our various communication

vehicles to the members. We repeatedly reminded them before the program and since the program about how it impacts them and how they can also find these guidelines if they so choose and review them.

The number of complaints, appeals of denials from the members, from the patients has been just a handful, truly just a handful. The feedback we got from physicians was that if the guidelines aren't met, in fact usually they're happy because they can tell the patient who's demanding a test that they really don't need it and it's Highmark's fault. And so it becomes, in some way, a tool for the physician to help with just knowing when is the best time to do the test.

But we also chose not to use this information for our public release. We are in the throes of releasing information about practitioners, hospitals, giving it to the public. Since we don't know the quality of the outcomes, since all we're looking at is utilization rather than whether or not the end outcomes were affected, we're afraid to just concentrate and make this information about utilization. We think it will give the wrong impression about the providers.

Unless we can tie it into the quality of the service, we don't know that it's very valuable patients. It would maybe make a practice look like they have inappropriate utilization when, in fact, they don't. Or vice versa. So that's been our concern. Until we get more information, we don't want to release it.

MS. HANSEN: Dr. Vinson, actually I wasn't asking more the profile of the practitioner. It was really the educational component of it and the understanding of the utility of the tests in terms of the pros and cons and if you weren't going to get what you should do.

So yes, I wasn't really going there at that point. Thank you.

MS. DePARLE: I want to thank the panel. You managed to very efficiently both convey both, Dr. Douglas, the critical nature of imaging as an advance in medical science which I sometimes think we skip over a little bit.

And secondly, the fact that some things can be done to make sure that testing is done more appropriately.

But thirdly, and I'm looking at Dr. Vinson because I think your example is very compelling in this, how difficult it is to get this right. And the example, I

was looking at Dr. Borman during the example you gave about the CT, the four different versions of the CT of the abdomen. And how do you know? You said your RBM ended up denying two of them?

DR. VINSON: We just decided arbitrarily that would go with two out of the four because we couldn't really back it up with evidence other than everybody, all of the radiologists, all of our other advisers said no it's ridiculous to order all four. But they couldn't really give me a clear reason of when do you not order the chest? So that's why we did that.

MS. DePARLE: That's why Dr. Castellanos or Dr. Borman is sitting there and what do they do?

You don't have to go through a rulemaking process. I'm not going to minimize what Highmark has to undergo in its markets, because you have to justify what you're doing. But I think for Medicare that kind of thing will be very difficult.

Not to say that there aren't a lot of good tools that you've given us. And one I just want to highlight quickly and ask you about because you didn't talk about it is privileging, which is something that some of us on the

Commission talked about and made some recommendations about two years ago but not all the members -- some of them are new -- haven't heard about it. And I'm interested in how that went when you implemented it? And how you plan to move forward with it?

DR. VINSON: We have finished the privileging. It was very successful in that we were able to get almost all of the practitioners and I think 82 or 83 percent were approved for everything they requested. Most of the denials were around podiatrists or chiropractors who did not have a technician and did not want to hire a technician, which we insisted they should.

There was some problem, we still have issues with particularly orthopedists, who want to have extremity unit MRI machines in their offices. They're not accredited machines. And we still have a problem because it is a major revenue hit on those practices if we don't allow them to do those procedures. But until accreditation -- which is in the process. But until that comes out we've got a problem with that particular part of our program. Otherwise it's been relatively successful.

MS. DePARLE: Thanks.

MR. HACKBARTH: Let me just pick up on your comment for a second, Nancy-Ann. Our recommendations of two years ago now, I guess it was, were that there be certification and quality standards established both for the technical and the professional components in order to participate in Medicare. Privileging is a term that I sometimes associate with not just having quality standards but maybe utilization base standards and creating a network. And so I wouldn't quite characterize what we recommended as privileging. It was strictly a quality based standard for participation in Medicare.

MS. DePARLE: Maybe I'm using the wrong terminology but I think what they're doing is what we described. What do you think, Dr, Vinson?

DR. VINSON: We called it privileging because credentialing is the first step of letting somebody into our network. And then the idea that once somebody is credentialed, can they be privileged and now perform -- I this case imaging -- within their system?

We decided not to add utilization measures. We decided not to put contracting measures who would take the lowest price into our privileging. Other plans could do

that. So I have to qualify that. Our privileging was based on qualifications and the quality of the service but that's not necessarily true with other plans when they describe privileging.

MS. DePARLE: That's why I viewed it as analogous to what we said, because we did not impose any utilization on it either.

MR. EBELER: Thank you. Just by way of disclosure, I'm an alumnus of HealthPartners and it's always an honor to hear what you've been now that you have competent people working there.

[Laughter.]

MR. EBELER: I just want to go back, Bob mentioned the water we drink in Washington here on costs, and try to just convey a little bit of why that, I think, is essential for the very focus of starting and ending with the patient we've talked about. The reality is we've reached a level and a rate of increase in spending where patient care is less and less -- coverage and care is less and less affordable to the very patients we're talking about. And to the degree that we absorb money in areas like imaging, there is less available to pay for things

like primary care. It's a direct reduction on other equally essential services. So I think that's the perspective we're trying to blunt here.

The goal is to deal with that through clinically appropriate instruments like we're talking about so that our successors sitting here a number of years from now don't have to turn to much uglier and blunter instruments. So I think keeping the patient at the center I think also requires this intense focus on looking at the spending.

In that context, as I understand the research one of the things one looks at in things like imaging is not necessarily the multiple tests that you described, Dr. Vinson, but for the patient with multiple chronic conditions, repeat and multiple tests often by multiple providers who don't know about the other tests. Are there things that any of you are doing in that arena to get to that issue?

DR. VINSON: We do monitor, because of the referral authorization process the reviewer has a connection to our claims system. They can see if these tests are being repeated. It becomes part of the discussion of why is this test being ordered again? It

goes back to the guidelines, they're supposed to incorporate their reasons, appropriate reasons to repeat the test. But if those reasons aren't being met then there's a discussion.

So we do try to use that situation within the way the decision is made. But that just started with this year, year and a half of use. So I don't know whether or not it will continue to have the effectiveness say in five years, if we'll be able to keep going back and looking to see if the test is being done let's say twice a year for no great reason, we should be able to track that. But it is something we're aware of.

DR. REISCHAUER: Do you have any idea of how many times the conversation is with one ordering physician why did you know that Dr. Y had the same test done three months ago?

DR. VINSON: I don't know about that particular type of situation. I do know --

DR. REISCHAUER: It's just a theory that that happens but we don't really have the data on it.

DR. VINSON: It does come up and they don't know that. And the patient, you would think would know that

they just had an MRI five months ago. But sometimes they don't. They get the tests mixed up and they're not sure, MRI, CT, echo, what was it? So yes, it does happen.

DR. DOUGLAS: We have a little bit of experience that can shed some light on this. The appropriateness criteria have very explicit repeating intervals under certain circumstances. For instance, if you have mild to moderate valvular heart disease, a leaky valve, or a narrowed valve, and you have no change in symptoms, it's not appropriate to get an annual echocardiogram. If you've received a successful angioplasty or bypass surgery, it's not appropriate to get an annual stress test in the absence of any change in the clinical situation. So they are very explicitly built into their criteria.

In looking in the implementation of the real world nuclear cardiology piece, about half of the inappropriate tests are these annual post-revascularization tests, which to date at least physicians have been very amenable to saying oh, I don't need to do that? And there's a guideline that will support me when the patient drops dead? Cool, let's not do it.

Somebody talked about the defensive medicine piece of this, and if you've got somebody with known coronary disease and you're not testing them, there's a concern that there's a liability and exposure there. If you now have a guideline in place that says you don't need to do that, in fact you shouldn't do that, that physicians have been very welcoming of that.

DR. COURNEYA: I would actually echo that point, that physicians are glad to have that information in hand when they're trying to make a decision. One of my preceptors when I was going through training had a saying don't just do something, stand there. The idea being that you need to be thoughtful about what you're doing before you make a decision because you can cause harm with the things that you do.

There are actually a few levels where uncertainty creeps its way in. A good example, it relates to radiology and it's something that one of my oncology colleagues says is that the frequency of follow-up scans for managing different types of cancers is not necessarily clear. It is pretty much the personal decision of that oncology provider.

And again, sitting down at a table and coming up with guidelines forces you to ask the question about frequency and then defend the answer you create. And if you can do that and create standards, then you can follow up and see whether or not it has an impact. So that's a very important part of this.

Another good example is with regards to drug monitoring. The guidelines are often follow up periodically with nothing more specific than that. You can have a 30 percent reduction in cost by reducing from three times year to two times a year and no significant impact. So it's really an issue of asking the question, creating the expectation of guidelines, and then setting yourself up for having to defend the answer.

DR. VINSON: We had that same experience with PET scanning that one of the local oncology centers wanted to repeat the PET, it seemed like every month. We forced them to come back and help us come up with frequency guidelines that weren't there before.

DR. COURNEYA: There is one other point, one of the reasons for having daily data exchange is it is another place where there is information that says this patient had

a scan just a month ago or three months ago, is it necessary to do it again? Also, as automation expands, having access to that information is a lot easier in the exam room.

MS. BEHROOZI: I'll be really brief.

I'm so grateful for this piano because the union funds that I run, we're about to go live on October 1st with a prioritization program actually.

And Jennie, the point that you raise about the consumer education and what you described about having to get the buy-in from the beneficiaries is so important because even though it's been awhile since HMOs have really been denying care the way they were in the '90s, that's still the big bugaboo out there and very important, I think, for the Medicare program to keep in mind.

So thank you all very much.

DR. BORMAN: I have really enjoyed the presentations and I'm trying to link it to some of our ongoing context in which we're trying to put this. And so I'm going to ask you some things that may not be quite so specific to your presentations but help us think forward.

One is that there's the issue of developing guidelines as around test-specific versus disease management. And I think that my sense is it's a little easier to develop them and feel good about their validity -- test specific, that is, what can this test do for you as opposed to the test or whatever?

But when confronted with the less differentiated, the abdominal pain example, for example, that's where the guidelines potentially may make bigger impact, would be my sense.

Can you tell from the work that you've done, any of you, whether that disease management-based guideline versus test-based guidelines, which of those is of greater value? So that would be one question?

DR. VINSON: We recognized that distinction and we decided to go with the condition of the patient, how the patient presents rather than the test. Our vendor wasn't necessarily in agreement with that. They looked at it more as a test-specific, so we had to make some modification. And some of the vendors go the test route versus the condition route.

We decided to try to focus on the condition, the test as it related to the work up of the condition, as being our primary approach. But it doesn't work every single time for the reasons I stated, that the guidelines are not necessarily as clear about the condition work up as they are about the test.

DR. DOUGLAS: I would actually say that the appropriateness criteria that we've developed are a third set of guidelines. So we have very robust guidelines that are based on the technique. So if you ever need to know how the heart valves are working, you can get an echo. And then if you have valvular heart disease, you can get an echo.

But the question is do you have a patient who has no moderate disease, who has a change in symptoms, is it appropriate then to get those or not? So there's the technical guidelines which tell you what the tests are capable of, and then there's the disease guidelines. But then there's also the very specific clinical scenario. That's what the appropriateness criteria are. They really drill down from the disease guidelines, which are a little bit sort of blue sky and textbooky, into a real-life

situation between a doctor and a patient and what is the patient complaining of and what is their history and what do I do from here?

DR. COURNEYA: I think part of what you have do is take into consideration the decisionmaking process of the provider, as well. Often by the time they get to a certain point in an exam, they've made a tentative decision about what kind of tests they want to try to do to understand what's really going on.

So I see these as kind of a both/and circumstance, where the guidelines may be test-specific but that's because that's the trigger point where the physician is going to try to lay their clinical circumstances up against the tests that will find the right result.

As long as those guidelines when the test is inappropriate based on the clinical circumstances says in this case it doesn't help or in this case an alternative exam will be more useful, you actually are connecting the specifics of the clinical circumstance with the right test or no test if that's appropriate.

DR. BORMAN: Glenn, if you can spot me one more question.

MR. HACKBARTH: Only for you.

DR. BORMAN: I'm going to forego a whole bunch of them.

It relates, in part to the work of the Commission I think, as distinct from the very fine work that you are doing. And that is again putting this into a context.

I think what we've not touched on today is the relative value to the patient of this class of services in the context of all of the services that we provide to the patient. There's the appropriateness of each of these. And this is a fundamental step that we have to take. But then part of the work of people in this room, including folks sitting out there and the hard-working staff, is to try and say where is the value in the context of the whole patient care?

I would be interested in your thoughts on that. I am just going to throw out just an example that challenges me. I'm a general surgeon, by the way, with special interest in endocrine surgery, just so you know where I'm coming from. I'm an academic surgeon.

As I look at it, and just doing some quick calculations just on the Part B side, if I'm a primary care

physician and a patient comes to see me because its National Thyroid Awareness month and they told me to swallow in front of a mirror and I saw something moving my neck. It happens.

So a patient walks into that office, has that issue. Your primary care physician does a very complete evaluation, let's just say it's a level four new visit. They're going to get ballpark total RVUs about four.

I'm an endocrinologist, same person sees me as a consult level four and I have a sonar machine in my office so I can throw that in thing. And I find the nodule and now I can throw in two other services, putting in the needle and the guiding of the needle. And now I'm up to 10 plus. Plus, if I throw in the office visit I'm even -- I'm really sailing now.

So there's obviously some increment there that we've got to decide what's right about that.

And then as I take that whole package that I've put together for that, that's pushing 13.

If I take half your thyroid out, you give me barely twice that and I take care of you for 90 days at 27.

Now I'm not saying that I'm necessarily worth more not getting right. I'm just trying to say do we have the balance there?

There's a host of those. And a bunch of this and one of the things I think the Commission -- because we've commented before about setting values -- is we also need to send a clearer message about our administrative datasets. Because I know from my life in CPT that the sense there has been that administrative datasets need to be more granular to meet government goals because we want to research more out of them. Yet those very granular datasets lead to exactly this component building that distorts the values.

Nancy mentioned yesterday in some of the discussion about the unfairness or we think of them as rank order anomalies that are introduced by then these budget neutrality pieces that go on top of it. So I think that we need some input into how we put this in a relative value of all services.

MR. HACKBARTH: And you have 30 seconds.

[Laughter.]

DR. COURNEYA: I just comment that I notice some of the commissioners cringing when talked turned to needles.

I think where conflicts are inherent process is important and making sure that the right people are at the table. Again, I get back to accountability and transparency. Where we recognize that the structures as they exist threaten entire segments of the health care delivery system. It's really time to ask hard questions.

I want to touch back on the point made earlier by Mr. Hackbarth or was it Mr. Reischauer?

MR. HACKBARTH: If it was a good point, it was mine.

[Laughter.]

DR. COURNEYA: Then I'm sure there's where it was.

Finding credible and appropriate ways to take the value and make that a part of the conversation in the development of the guidelines. What actually are you bringing forth? What are you adding to the process? And until we can have that conversation and make value, make cost a part of the conversation, even among physicians, in

an open forum it's going to be really difficult to solve those problems.

DR. VINSON: I would echo those same sentiments. One thing we've been aware of is this idea of squeezing the balloon, that if we squeeze down, in this case MRI, the patient will just go and have 20 more PT visits before they get the MRI anyway. We just delayed it.

We've been trying to address that question. Practitioners bring it to our attention all the time even though they can't necessarily give examples or much less statistics about it.

But when you talk about value, that has to be considered. What happens with the delay and the test gets done anyway? I think that is something that has not been well researched but probably ought to be because it comes up in our conversations all the time.

DR. DOUGLAS: I just second the need for research and try to understand what those different processes of care, seeing a primary care physician for a problem versus seeing an endocrinologist versus seeing a surgeon. There is a total cost to it. If they need to have their thyroid out, there's obviously a lot of efficiencies to go directly

to the surgeon. I don't know what the right pathway is. It's very hard.

MR. HACKBARTH: Okay, thank you very, very much. That was very informative and we appreciate your taking the time.

Okay, we will now have our public comment period. The ground rules for the public comment period are first, identify yourself please. Second, limit your questions or comments to no more than a couple of minutes each. And then third, if somebody before you had made the comment that you want to make, just say I agree with so and so, no need to repeat it.

So you have the floor, sir.

DR. NEIMAN: My name is Dr. Harvey Neiman and I am the Executive Director of the American College of Radiology.

I appreciate the opportunity to speak to the points raised by the panel this morning. I will keep my comments brief as I think there's been an outstanding discussion of the issues.

The ACR has a long history of developing quality programs for the appropriate use of all imaging services,

including the high tech modalities. The ACR's appropriateness criteria were developed beginning in the mid-1990s as a tool to help referring physicians make the best imaging choices for their patients. I want to emphasize that the ACRs appropriateness criteria are developed and updated by panels of expert radiologists with significant input from non-radiologists specialists, including cardiologists, urologists, and endocrinologists.

As we have heard. they are not all inclusive but we've been working at it for almost 15 years. But to give you some idea of the vastness of the work, we have over 165 clinical conditions that have been covered with variants that takes it to about 800 clinical conditions that have been given an appropriateness criteria evaluation. These are disease management oriented. They are based on the clinical condition of the patient and then rank ordered the tests that are recommended by the experts.

The ACR believes widespread use of it's appropriateness criteria by referring physicians can have a significant positive impact on imaging utilization and cost as well as patient quality of care.

In addition, the ACR has developed many other programs focused on the quality of imaging. The ACR accreditation programs ensure high quality imaging by setting standards for equipment, physician, and non-physician personnel and exam quality.

We've also heard about registries today, and in particular the PET Registry. I want to emphasize that this is an initiative of the American College of Radiology with its partners such as CMS, the Academy of Molecular Imaging, and others.

We've also heard about two models or several models of utilization management, one of which is based on real authorization precertification and we are concerned that this can create a significant administrative burden of both referring physicians and radiologists.

Without going into details, we are supportive of the order entry decision support concept that originated at the Massachusetts General Hospital Partners system, based on the ACR's appropriateness criteria, and feel that this system encourages continuous quality improvement in ordering patterns through both immediate and retrospective educational feedback on the rankings of the tests ordered

by the referring physician. MGH Partners data shows referring physicians significantly improve the appropriateness of exams ordered after receiving profiles of their ordering patterns.

Therefore it is the hope of the ACR the MedPAC advise the Congress of the use of facility and personnel accreditation along with the use of evidence-based appropriateness criteria reviewed and vetted by expert physician panels can lead to an overall improvement in quality of imaging studies being provided to beneficiaries and can better ensure that the appropriate study is done for the patient.

Thank you.

MR. SNYDER: Good morning. My name is Keith Snyder and I'm speaking on behalf of e+plus Healthcare. e+ is a Nashville based PET CT provider with centers in four states and focusing exclusively on cancer patients within Medicare. And they make up about a third to a half of the patient volume at any given center for e+.

I wanted to point out, and I appreciate the discussion today specifically on appropriateness criteria, that PET is already covered by very strict payment criteria

in Medicare. You have to meet these payment criteria in order to be reimbursed. You can do scans that don't meet them but you just won't be paid for them. This was developed, as was mentioned earlier, as part of the coverage with evidence development initiative in the Medicare, CMS, and continues through the PET Registry, which also has been mentioned heretofore.

We wanted to again thank you for this discussion on appropriateness, but also point out that this payment criteria structure that PET is under makes it different and eliminates a lot of the concern about abuses and overuse that you are justifiably concerned about.

We also would like to point out that while we appreciate this discussion, we feel that to this point MedPAC's work on imaging hasn't really recognized the uniqueness of PET, its payment criteria uniqueness. And your references to increase in volume on nuclear medicine, which includes PET and PET CT, have failed to take into account the fact that it's a new technology and you would expect rapid growth. It didn't receive its first coverage until 1998 and then was expanded from 2001 to 2005 to other types of cancer and now is paid for and covered for 10

types of cancer for particular uses, staging, restaging, and monitoring within strict time intervals.

I think Dr. Vinson earlier today mentioned the rapid growth they've seen in PET, which is evidence of this, which you would expect in a new technology.

We think it's especially important to talk about appropriateness criteria and guidelines rather than across-the-board reductions which have been the preferred tack up to this point. I'm referring especially to the DRA cuts which were not targeted and were not vetted as to their effect on access. And PET, in particular, received the reduction of about 40 to 50 percent.

So we welcome this discussion and we encourage you to look at both the effect of cuts like DRA and also their impact specifically on the cancer population. And we'd like to offer to work with you in any way we can in the future as you continue this discussion.

Thank you.

MR. WHITE: I'm Joel White. I think I met some of you before. I was the former staff director of the Ways and Means Health Subcommittee and am currently representing the National Coalition on Quality Diagnostic Imaging

Services. These are the independent diagnostic testing facilities that do not self-refer and are not physician office based. They are not hospital based. I'm here to give just a few comments on what I see in terms of the presentation today and perhaps moving forward as part of the March MedPAC report.

As I said, IDFTs do not self-refer. They are also unique in the Medicare statute in that they must comply with quality and safety standards that physician offices and hospitals do not have to comply with. In fact, in MedPAC's 2005 March report recommendations to the Congress, you all recommended that quality standards apply across the board and we strongly support that and favor that as a way to get at inappropriate increases in utilization that we're seeing in the imaging field.

One of the things that we did, and some people blame me for the Deficit Reduction Act. I take credit for it, I suppose. Was that we were trying to equalize payment, at least on the technical component, between the HOPPS rate and the physician fee schedule. What we discussed when we were in the room with the various chairman was an issue of

intuitive equity, that the rate that should be the same regardless of the site of service.

What we didn't do is fully level the playing field. That is, we didn't extend the quality standards that apply to the independent facilities across the board. And we would strongly encourage MedPAC, in their March recommendations next year, to encourage Congress to apply that across the board.

My comments on the use of prior authorization or RBMs are that MedPAC should step lightly, that this is an area that probably needs some additional investigation. I can tell you two things. One, the data that was presented to you by MedPAC staff -- and by the way Mark, Sarah, Annissa, and Ariel are doing a great job for you all -- was 2005 data and therefore does not include the changes in the DRA that have just been enacted beginning in 2007. So that's one limitation.

The second thing I would point out, as Annissa answers her cell phone, the second thing I would point out is that use of prior authorization or RBMs, the third-party type folks, will insert another layer of at least administrative costs between the beneficiary and the

provider. And that cost will be born out by the taxpayers ultimately, and probably in additional premiums and coinsurance by beneficiaries.

The second point I'd like to make is that with the use of RBMs you are not addressing fundamentally the ultimate issue of utilization. When you think about the use of one time, two-time, three-time, four-time, multiple imaging service tests that are read by substandard technicians or because the machine is substandard or there are safety issues with the machine, even if that's approved prior when to the patient needs the service, without extending those quality standards you are not addressing the underlying issue. And that's why we would argue that MedPAC, at least in their March report, should make that recommendation.

Thank you for your time.

MR. CLANCY: Thank you. I'm Dean Clancy with Sidley Austin, LLP. We have the honor to represent the Society of Diagnostic Medical Sonography. SDMS is a national nonprofit organization representing more than 20,000 diagnostic sonographers around the country. It's the largest sonography association in the world.

SDMS strongly supports mandatory credentialing of sonographers as the surest way to ensure quality and cost effectiveness.

We just want to draw your attention to the GAO report that came out in June on the question of ultrasound credentialing. GAO recommended that CMS should require credentialing of sonographers or accreditation of facilities. SDMS feels that accreditation of a facility is a good thing but it's insufficient because the technical director could be qualified but the people who actually have the transducers in their hands doing the ultrasound exams may not meet minimal levels of competency. Therefore we think credentialing of the technical personnel is also indicated.

We're happy that MedPAC has come very close to endorsing this position. I think Chairman Hackbarth and Nancy DeParle referred to this today in the March 2005 report where you suggested that CMS should strongly consider setting requirements for credentialing of personnel. So we would urge you to revisit that as part of this assessment.

Thank you for your time.

MR. HARRINGTON: Good morning. My name is David Harrington. I'm President and CEO of American Imaging Management.

Perhaps more relevantly, I'm going to be reaching my 63rd year in a couple of weeks and so the issues that the Commission are considering are personally relevant and I appreciate everything you're doing.

I appreciate Ariel and his staff for the work they're doing, and the words from the panel and the other speakers.

I would just like to emphasize a couple three things. One is the growth that we're describing, that Ariel described, is just the tip of the iceberg. It's going to continue to grow and grow at a tremendous rate. You're going to have utilization rates in diagnostic imaging for Medicare 2.7 times the rate that we see in the commercial population, number one.

Number two, you're hearing about all the medical and surgical specialists who are also ordering, as well as the primary care doctors. So you have more ordering physicians, more rendering physicians. Guess what? There's no consistent national ordering process in

diagnostic imaging. Seniors are walking into facilities today and being handed a clipboard and being asked to fill out data on who they are or what they're there for. The test is being performed by a technical person without intervention by a doctor and then later on the doctors talk to each about whether or not the test was right. And technology exists to fix that.

The third thing I'll emphasize is that they are tracking technologies available to figure what tests have been taken, where they have been taken.

I'd like to take Ariel's growth chart and talk about how much CT really occurs. There's a real safety issue here that when you look at the escalating growth of CT and you take of those little growth areas what's been growing? There's a tremendous surge in CT, CT among seniors. CT are 500 x-rays equivalent. The technology exists to know what tests have been rendered -- Dr. Courneya referred to that -- and where those tests are so those tests can be reviewed and reused instead of new tests administered. The technology is there. It's not being used.

I'd like to say from our standpoint, because I've been identified as a radiology benefit manager, is that we manage risk. In other words, we are at risk for the payments to providers on behalf of some of our health plans. We don't say no. I want you to hear that loud and clear. What you heard from Dr. Courneya is our business philosophy. That is, in order to manage care you don't need to say no. You need data. You need to measure in order to manage. We want data.

I want to really emphasize that. At American Imaging Management we have 40,000 doctors who use our website, both ordering physicians and rendering physicians. We have 45 percent, we have over 9,000 orders a day that are occurring and being received and approved without human interaction. And I wish it were 100 percent.

Interestingly, places like Western Michigan, the use rate of the Internet is over 70 percent. Minnesota is doing the same thing. This is something, we don't need to be in the way, we shouldn't be in the way. We shouldn't disintermediate the doctor and the patient and the plan. We should offer software tools, clinical decision tools that lever the process, that make it clear and easy.

We, at American Imaging, stand for that. We very much support what Harvey Neiman said in terms of a philosophy, in terms of how to approach this area.

I love what Dr. Douglas said but I did agree a little bit with the comments that I wish the medical and surgical specialties were as aggressive about developing criteria as they are about allowing all of their members to be experts in the use of all of the new technology and really marry with us to develop the appropriate criteria and collect the data.

Thank you.

MS. MARKS: Sandy Marks with the American Medical Association. I just wanted to point out that what we've seen in our analysis of the Medicare claims data is that what's happening in Medicare is not different from what's happening on the commercial side.

We have looked at the preliminary claims database for Medicare for 2006. We found that 60 percent of the additional payments for advanced imaging last year were related to a single service, code 78815, for tumor imaging PET with concurrently acquired CT for attenuation

correction and anatomical localization skull base to mid-thigh which grew 86 percent from 2005.

This is directly related to the information you heard today about the continuing rise in indications for PET scans for tumor localization and the CMS expansions of Medicare coverage for PET can technology.

MR. HACKBARTH: Okay. Thank you all, and we'll see you in three weeks. The meeting is the first week of October.

[Whereupon, at 11:25 a.m., the meeting was adjourned.]