MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, October 8, 2009
9:44 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, J.D., Chair
FRANCIS J. CROSSON, M.D., Vice Chair
MITRA BEHROOZI, J.D.
ROBERT A. BERENSON, M.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
PETER W. BUTLER, M.H.S.A.
RONALD D. CASTELLANOS, M.D.
MICHAEL CHERNEW, Ph.D.
THOMAS M. DEAN, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
HERB B. KUHN
GEORGE N. MILLER, JR., M.H.S.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. At our meeting today and tomorrow, we've got some interesting items on the agenda. We're going to have draft recommendations that we'll consider this afternoon. That's the first time we're actually looking at recommendations in this cycle. As always, we will have draft recommendations, no vote today. This is on the mandated report on how to measure quality, compare quality in fee-for-service and Medicare Advantage plans. So we'll consider draft recommendations today with a final vote at some point in the next few months. I'm not sure when that will actually fall.

This afternoon, at this afternoon's session, we'll have a camera here from C-SPAN. C-SPAN will be taping the afternoon session. It won't be live, it will be delayed and shown at some point later. Hopefully, that won't be too disruptive for people in the audience.

As always, we'll have our usual public comment period at the end of each session. In order to increase opportunities for people to comment on our work, we've added a new feature to the MedPAC website, and Jim Mathews is going to describe that so people can make use of it.

DR. MATHEWS: Yes. Starting with this meeting, we've added the capacity for you to submit written comments on the agenda items via our website. So if you go to the page on the website where we post the meeting agenda, you'll see under each agenda item there is a drop-down box that will allow you to submit comments.

We are going to try this out as a matter of routine, and we will begin soliciting comments on the meeting agenda items at the time the agenda is posted, and we will keep that comment period open for one week after the meeting.

MR. HACKBARTH: Thanks, Jim.

Let's turn to our agenda for this morning. The first topic is medical education.

MS. BOCCUTI: Thanks, Glenn. So at the outset of this presentation, I want to say that teaching hospitals and residency programs are really doing a tremendous job teaching our future physicians how to be excellent doctors for their patients and for their community.

Nonetheless, the Commission over the last year and a half has raised some issues about medical education. Some of these are related to market forces, but others are

related to subsidy structure within the financing. So we're going to talk about some of those today.

So just to give an overview of this session, first, we're going to talk about some background issues that came up from the last meeting. So these are more informational. First will be about Title VII and Title VIII and the National Health Services Corps which came up, and Craig is going to talk about Medicare's residency caps and residency growth. And then we'll move on to the discussion about goals of medical education and training and problems that you've been discussing with the current system. And then we'll end with opportunities for addressing some of those problems.

So first, again, as a background piece, HRSA runs several programs to boost the supply and diversity of primary care providers in underserved areas. Grants in Title VII and Title VIII support many initiatives that have been of interest to the Commissioners, that you have been raising. So to mention a few, these Title VII and Title VIII programs provide medical school and residency support for primary care. They also provide geriatric training support and support for various programs at Historically

Black medical schools, and they also provide faculty enrichment and loan repayments, among many other programs.

The National Health Service Corps provides loan repayments and scholarships to health professionals in exchange for a two-year commitment to practice primary care in underserved areas.

The important point to know about these programs is that they have been shown in peer review literature to be associated with supply increases of primary care providers, and that includes physicians, nurses, and others. For example, physicians who trained at medical schools that had Title VII funding were more likely to enter primary care, work in shortage areas, practice at community health centers, and join the National Health Service Corps.

I should mention that for these three programs, they're subject to reauthorization and annual appropriation processes.

Now, Craig's going to give you the other background information.

MR. LISK: At the last meeting, we had some questions on the resident caps and how Medicare counts residents, so I just wanted to clarify how that is done and

what happens here.

For direct GME payments, Medicare uses a weighted count of residents. Full-time residents in their first residency program are given a weight of one in terms of the count of residents. Residents in their second residencies -- that would include things like cardiology or hand surgery after finishing a general surgery residency -- are counted as half an FTE. And if residents take longer to finish their residency training, they are also counted as half an FTE. So if they decide to take an extra year, they would be counted as half an FTE for that purpose.

These weighting factors, though, are not used for the Indirect medical education adjustment count of residents. All residents are counted the same for IMEs. So there is no distinction there.

The count used for residents is also capped at 1996 levels. This was implemented as part of the Balanced Budget Act of 1997 to curb the financial incentives hospitals had for growing the size of their residency programs.

Rural hospitals, however, were given a cap of 130 percent of that amount. So they had a little bit higher

cap. And exceptions were also made for certain programs, such as new programs in rural hospitals so that a rural hospital could start a new training program that they already didn't have, rural training tracks in urban hospitals, they are based in urban hospitals, and hospitals that previously had no residents.

The MMA legislation also provided for some redistribution of unused residency slots. So for hospitals that were below the caps, they were allowed to -- those slots were redistributed to hospitals that were above the caps or wanted to expand residency training programs.

The MMA and the health reform proposals up on the Hill, both on the Senate and House sides, are considering some redistribution, again, of unused slots targeted to primary -- more or less targeted to primary care, although we will see what happens there.

Now, hospitals are permitted to train over the cap, but Medicare will not provide any additional IME or GME funds for those residents. And in 2006, from an analysis we have done on the Medicare cost reports, we find that hospitals are training about 8,000 FTE residents over the cap. So hospitals have these residents, but they are

receiving no Medicare direct GME or IME payments for these residents.

Hospitals that are over the cap, we find, have a lower share of primary care residents in terms of the proportion of residents that they train, and we plan to update this analysis to 2008.

Since 2001, we have seen substantial growth in the number of residents, an increase of about 12,000, despite the presence of residency caps. This is the total number of allopathic residents. It doesn't include residents that are in osteopathic training programs or dental and podiatry residents.

This growth has two parts. The number entering training for the first time has increased since 2001 by more than 3,000 residents. This growth in these positions contributes to the increase, as each resident requires three or more years of training. Also, the total number in training has increased due to increases in the proportion of residents subspecializing, which requires additional years of training.

If we look at this next slide, we are looking at residents that complete training in a given year and either

pursue further subspecialization or enter practice or don't pursue additional training. And as we see here that more residents are subspecializing and fewer are entering generalist careers.

If we look at the primary care side, which includes internal medicine, pediatrics, and family practice, there has been an increase in the number subspecializing in fields like cardiology and gastroenterology, an increase of 1,100 since 2000, and a decline in the output of generalists of more than 1,800. So that is the red bar there.

We see a similar situation for surgery specialties, with fewer general surgeons and fewer in other core surgical specialties, like orthopedics and urology. I should actually say not orthopedics, because orthopedics is constant, but neurology and urology. But within the surgical field, we are actually seeing additional subspecialization. So both for general surgery and within those other surgical specialties, people are pursuing additional training and taking more time. So that is also contributing to our increases in the number of residents.

So with that, we will move on.

MS. BOCCUTI: Okay. Now switching back to medical

education and training issues, we are going to start here with a few bullets that list broad goals, so here are the first.

We have to ensure that students possess the knowledge, skills, and values necessary to provide high-quality health care. And second, to produce a workforce that best serves the needs of our society. And third, we listed here as a goal to become leaders in forming a high-value health system.

Now, as you know, individual hospitals and residency programs have their own missions, but this, we thought, could reflect broad goals. But if we want to add some here for further work, this would be a good time to mention these for goals.

And then next slide, please. So over the past year and a half, you have raised a range of problems that you see with medical education. These problems span a continuum of issues inside and outside of Medicare payment policies. So to help sort out all the problems that we've been raising, we've categorized them into three issues. Of course, there's some overlap, but to help the discussion, the three issues here are pipeline issues, delivery system

reform issues, and economic inefficiencies.

So for the pipeline issues, the first four bullets up here are not necessarily specific to Medicare financing. Craig just talked a bit about the first one on generalists, but I would also mention that certainly there are specialists and specialty fields that are facing shortages, too. But this is specific to an area that the Commission has raised a concern about, and I certainly recall from the physician update conversations. I think Mike and Nancy and others were talking about a need to express some urgency about primary care and that led to the repeat of the recommendation to adjust payments through the fee schedule.

The second bullet there on underrepresented minorities, rural students, and low-income students was also discussed in our June report, just this recent June, and I do want to mention that studies certainly have shown that students from these backgrounds are more likely to enter the field of medicine with the intent to care for patients in underserved areas, and several of you have brought this up. I think George and Ron and Mitra have been bringing these issues up.

The third bullet there about medical school

admissions, Tom has brought this up. I think John mentioned this to me recently. The issue that many have raised that the criteria for medical school admissions and the standardized testing may, in fact, be eliminating some extremely qualified candidates that are able to diagnose, treat, and take care of their patients.

And then in that fourth bullet under the overall problems, Karen and Bill have raised this point about perhaps a better use of mid-level professionals could alleviate concerns about primary care and, indeed, other services.

And then turning more specifically to Medicare financing for medical education, we note, of course, that Medicare's focus is on residency training. So this circumstance means that Medicare is generally too late in the process to affect the pipeline of physicians.

Also, Medicare's GME and IME influence also has little influence on the specialty mix and the training location of residents, as Craig described in the way that residents are counted for and paid for.

And third, as Jennie has pointed out, the focus on residents really limits Medicare's financing for education

and training of mid-level professionals, like nurses.

And so turning to delivery system reform issues, we note that the IOM, expert panels, peer-reviewed research have all stated that residents have insufficient experience in coordinating care across settings. Much of this stems from limited time in non-hospital settings, and we discussed this in the chapter in just this -- it seems like a long time ago, but just this recent June 2009 report.

As Karen brought up, inpatient experience is essential for residents to learn about serious, acute illness, but there does seem to be a need to balance that with adequate and sufficient experience in non-hospital settings.

The other point there, about curricula, the Commission discussed this in its recent report, so I don't need to go into it.

On the pipeline issues, we put up there just because some of that feeds into delivery for reform when we talk about having a well-functioning system that has generalists to support it.

And then moving on to specifically with regard to Medicare GME and IME financing, we note, of course, that

payments are tied to inpatient admissions. This creates some problems. Namely, hospitals really do face financial incentives to retain residents within their complex for staffing reasons, and moreover, the subsidies further influence staffing decisions.

And the other issue with this situation is that linking the subsidies to hospital admissions is somewhat mismatched with the overall goal to improve ambulatory care and prevent avoidable hospital admissions.

So on to the third category here, we have the economic inefficiencies. Government payers are really the major explicit funders of medical education, yet there is really no central workforce planning to coordinate all these subsidies. And I said explicit because some private insurers contribute indirectly through higher patient care payments to teaching providers. And I should also note that a small number of States require private insurers to contribute explicitly to graduate medical education, and I believe New York is one of them, so Mitra probably can speak well to this.

And then the subsidies, for the subsidies there, the problem that we raised about the Federal subsidies

influencing the hospital decisions also plays here when we talk about economic inefficiencies.

And then specifically to Medicare, we have the financing issue that I know most of you are aware of, with approximately $3 billion of IME going towards costs that are not attributable to higher inpatient care costs, and Craig has done a lot of the calculations for this and I am sure he could answer any questions on that topic.

So there are many ways that medical education could be reformed, and we listed many in your briefing materials for this meeting. However, we're going to narrow the focus somewhat on just a few issues for the close of this presentation.

For pipeline issues, we have two here on the slide. First, recognizing that there are programs outside of Medicare, specifically in HRSA, that are geared toward the supply, diversity, and distribution of health professionals, perhaps enhancing these programs would be an effective way to address some of the pipeline issues that we have been raising.

Second, directing a portion of funding to residency programs could give them more autonomy to develop

learning venues in well-functioning office-based practices and clinics. Residency exposure to these kinds of environments could encourage greater appreciation for primary care careers. And I think several of you have discussed the problems with the harried environments that residents are facing and perhaps this could address some of that, and I'll stop talking on that and move on.

Under delivery reform, we have the item that I think Peter and Arnie and John have been discussing about optimal training environments. So if Medicare provided incentives for graduate medical education to occur in such optimal training environments, then not only will the residents be more likely to learn the skills that they need to deliver high-quality and efficient care, but the patients will simultaneously be benefitting from this learning experience.

Academic medical centers could be ideal candidates for participation in demonstration projects that are testing delivery system reforms, such as the one that MedPAC has recommended for ACOs. Here, on this topic, it would be very useful to hear your input on other ways that we could be linking subsidies to graduate medical education -- the GME

subsidies to delivery system reform ideas.

And finally, the portion of Medicare's IME that can't be attributable to the higher patient care costs could be reallocated to improve economic efficiency for the subsidy.

So here we have a graphic on the screen to demonstrate these items that I just discussed. Again, there's many other proposals out there, many that we've discussed and many that were in your briefing, like adjustments to the non-hospital regulations, some all-payer ideas, faculty expertise incentives, and specialty-based payments. We can talk about those, but we thought that narrowing it to these big picture items might be helpful for today's discussion.

So we welcome your discussion and we're happy to answer any questions. Thank you.

MR. HACKBARTH: Okay. Thank you, Cristina and Craig.

So we have a goal for this discussion and that's to begin the process of focusing in on where we think we might be able to make some recommendations. We've had at least three, maybe four sort of broad ranging discussions

where we've tried to learn a little bit about the broad area and explore subjects of interest to Commissioners. But now, we need to start trying to focus in.

Cristina has proposed one framework for trying to start to organize our thinking. Feel free to resist that, but we do need to start moving towards some more narrow directions.

As we go through the Commissioner comments, I am going to a little bit more aggressively enforce the rules. Round one is going to be clarifying questions. I hope people will not be offended if I say a particular question is better deferred until later. I'd really like to get to round three so we can start to, again, agree on future directions for our work.

So let me see hands for round one clarifying questions. We'll start with Ron and then come down this way.

DR. CASTELLANOS: Cristina, very good job. I really appreciate it. Your comments were excellent.

I am concerned about society's needs. What data do we have, if any, that can support our recommendations for what society's needs will be, hopefully, in the future, and

how are you using to identify that?

MS. BOCCUTI: I think we need to determine first how -- whether we're going to evoke that discussion in GME issues. I think the Commission has been clear on concerns about primary care when I've been doing the physician update analysis, et cetera. You need to be thinking about where that would fit into this and whether you want us to pursue more data with regard to that. Is that a fair --

MR. HACKBARTH: Yes, and we can come back to that, Ron, in subsequent rounds if you want to.

DR. CHERNEW: How good are the studies to try and quantify the impact of some of these things on the specialty choices that medical students make? Do they deal with selection well? Are they, would you say, well-done studies that we could be comfortable that the magnitudes are knowable?

MR. HACKBARTH: Yes. I'm going to enforce the rules here. Round one, I'd really like to get people to focus on what did you mean in Chart 3? What does that number mean? And again, Mike, we can come back to that. It's an important issue, but I'd really like to adhere to our discipline.

MR. GEORGE MILLER: I'm afraid to say anything.

[Laughter.]

MR. HACKBARTH: That means it's working.

[Laughter.]

MR. GEORGE MILLER: I have a technical question that is not on the chart, so I can't refer to that, but I do have a question about the National Health Service Corps. I've heard that those physicians who are given grants are then taxed, and that is somewhat a disincentive. Have you found that to be true, and what are the implications of more physicians going to that track? If that is true, will it adversely affect people choosing National Health Service Corps?

MS. BOCCUTI: I'll look into the tax policy on that.

MR. GEORGE MILLER: Yes. I realize that's not --

MS. BOCCUTI: I imagine it would be treated like other grants --

MR. GEORGE MILLER: Right.

MS. BOCCUTI: -- and I'll certainly make sure. I don't want to speak incorrectly --

MR. GEORGE MILLER: Right. And what I've heard,

just so you can chase this rabbit down, is if, well, I'm going to medical school, I'm not earning income. If I've got to pay taxes on that grant, I'm going to go find another job, and that's a disincentive.

MS. BOCCUTI: I want to just get the details correct, and I'll be happy to talk with you further on it.

DR. MILSTEIN: My question referred to Slide 12, the last bullet. My quick question is this. I know that in our prior analyses, we've looked at the relationship between how much we're paying and how much we think it actually costs, but could you remind me whether we have ever attempted, or maybe even whether it would seem feasible to essentially evaluate the degree to which teaching hospitals vary in the efficiency with which they train, that is, in these two dimensions. Or does this cost refer to industry-wide, and have we ever taken that apart and identified differences in the efficiency with which different teaching hospitals are teaching trainees?

DR. MARK MILLER: I think the answer is that this is a national estimate and we have not gone in and tried to determine whether the costs vary by hospital by hospital. This is a national number that we've always worked with, an

average across all hospitals.

MR. HACKBARTH: So let me just make sure that I understand. So you're saying, could we do at the hospital level an empirical estimate of the costs of teaching so we could see how that number varies across institutions?

DR. MILSTEIN: Yes. It's much more analogous to what we've done in Medicare payment, where if we have any basis for figuring out what the cost of efficient teaching is.

MR. HACKBARTH: Yes.

DR. MARK MILLER: And we will take that back and discuss it among ourselves to see. What I do want to do, as always, lower your expectations a little bit. My sense of the way that estimate is derived, it's basically through a cost function regression and it sort of is determined based on looking at the variation across them. I don't know that we're going to be able to go in and isolate it specifically for any individual hospital, but we can discuss that and come back to you on that.

MR. HACKBARTH: Any clarifying questions? Peter?

MR. BUTLER: Just curious. We've cited the 2.2 empirical number for IME, versus the 5.5 where it's at,

versus our 4.5, where we recommended. When was that calculation made, the 2.2? How old is that?

MR. LISK: That was based on -- now I'm trying to remember -- 2004 data. We are actually in the process of updating that empirical estimate with -- also with -- because MS-DRGs have been put in place to see what the estimate will now be. So we will be coming back with you with an updated estimate of that.

The other aspect of which I wasn't sure, and we'll talk about this, the direct GME is another component here, too, so --

MR. KUHN: I want to go to slide 4 and talk about the redistribution of the unused slots. If I remember right from the MMA, institutions that had unused slots, 75 percent of those were taken away for redistribution, so they were able to retain 25 percent and then 75 percent was redistributed.

I guess the question is do we have any information in terms of what the fill rate has been, not only for those institutions that retained their unused slots, but also the redistribution of the 75 percent that went around? I mean, are we still seeing -- the fact that Congress is looking at

another redistribution, it sounds like we still have a lot of unused slots, but I'm curious about what was the fill rate we saw from that exercise. Do we know?

MR. LISK: I can go back and try to check to see what those numbers are like, and as part of what we talked about saying in terms of updating the analysis to 2008. That, I can make as part of that analysis, to try to do that as best we can.

MR. HACKBARTH: Clarifying round one?

MS. HANSEN: I think the same question with the unused slots, if you -- anecdotally, I've heard that a lot of the geriatric slots have not been filled, or maybe that's -- I'm sorry. I'm correcting myself. I think it is the fellowships that are not filled, so it is not the residency slots.

MR. LISK: Right. And again, places could have slots and unfilled slots. It is really in terms of what the Medicare cap number is and what they have as unfilled. So hospitals could be way over the cap and have unfilled slots. But from this perspective of unused slots that are ones relative to the Medicare cap.

DR. BORMAN: Just a quick clarifying reminder.

Just because you have slots in one thing doesn't mean you can shift them pretty freely across residencies. So remember, even if you have funded residency slots, unless you are accredited to educate X-number of people in a specialty, you can't just move those excess slots over. And I know you understand that because of your relationship with an academic medical center, but just so everybody can remember, this is not sort of a free mix-and-match option.

MR. HACKBARTH: Other clarifying questions?

DR. DEAN: I appreciate Karen's comment, because that really was my question. I couldn't remember if there was -- are these slots identified by specialty so that -- because the overall number is just a broad number, right? It's not broken down by specialty in terms of the cap. But when they're redistributed, is it required that they stay in the same specialty, or --

MR. LISK: No, not in the MMA redistribution. There was some priority given to places that were rural or primary care initially, but that was not necessarily what happened in the end.

In the reform proposals, there is some consideration of the slots really only being -- in some way,

I'm not sure how, whether there are any ways they can get around it -- of them being more focused for primary care use and just for expansion, having some requirements that they hold their numbers down. But it depends upon what comes out in the final legislation is something is reformed. And that is in what is in the proposals now. But in the old redistribution, there wasn't --

DR. DEAN: Medicare does not have any --

MR. LISK: No.

DR. DEAN: -- requirements as far as specialty mix right now?

MR. LISK: No.

MR. HACKBARTH: So I'm a little bit confused here. Maybe I misunderstood what you were saying, Karen. So within a given institution, if it's operating under its Medicare cap, is it free to change the specialty mix of those residencies?

MR. LISK: Yes. I mean, it doesn't -- Medicare is having no impact on that in terms of what the hospital can do. I mean, they have to follow ACGME guidelines in terms of --

MR. HACKBARTH: Okay. So that was my

understanding of the Medicare role. So, Karen, would you explain your comment about there being restrictions? Those are non-Medicare restrictions you are referring to.

DR. BORMAN: Right. Those are non-Medicare restrictions, and that is driven by what you are credited to educate.

MR. HACKBARTH: Okay.

DR. BORMAN: So you could have funded slots, but if you don't have the accredited positions, you could not direct people into those.

MR. HACKBARTH: Okay. Got it. Could I ask about slide 5? I need you to sort of connect some points for me. I was struck to see the visual representation here and the slope of increase after 2001. This is in the context of Medicare caps that went into effect in 1996 or 1997. So why the rapid take-off after 2001? I can't reconcile that with the caps.

MR. LISK: I mean, hospitals can increase the size of their residency programs. Medicare doesn't prevent that from happening, so --

MR. HACKBARTH: So does this imply -- you said that there about 8,000 non-Medicare-funded residency slots.

This implies to me that those 8,000 all happened after 2001. Am I drawing an accurate inference?

MR. LISK: Basically, from 1997 to -- there was actually a -- when the caps were put in place, actually, the number of residency positions Medicare was paying for actually declined by about 1,000 to 2,000. And then growth started happening in 2001. There was growth starting with number of people entering residency training programs. That was held pretty constant from 1997 through 2001 and then started growing. So you had a number of people entering residency, allopathic residencies, increasing, and that actually increased by 15.5 percent over this period, and the total number of residents -- I mean, you have new people coming in. They're staying longer. So that contributes to the growth. And also people staying longer within the specialties and subspecializing further also contributes to the growth.

MR. HACKBARTH: Okay.

MR. LISK: So those three things are happening. Now, this is allopathic. We don't have the osteopathic specific residencies in here. That, I would assume, may have contributed even a little bit more to the growth. But

a lot of osteopathic residents go through allopathic residency training programs.

MR. HACKBARTH: Any other clarifying questions?

MR. GEORGE MILLER: Just to follow up on that point, that same graph, do you have the demographic breakdown of those residents, socio-economically?

MR. LISK: In terms of by race, there are some racial breakdowns of those, and --

MR. GEORGE MILLER: And income level, too.

MR. LISK: Not of income level. But in terms of what's supplied, we're using data that's in the JAMA's medical education issue to do some of these things, and they have some of that information, but not the income level.

MR. GEORGE MILLER: The shortages are in rural areas and inner-city areas. It would be interesting to know that information to reflect back on.

MR. LISK: No, I agree. I'm not sure what's available. We can look into it.

DR. BERENSON: On the same graph, also, it looks like, then, since 2001, it has been about a two percent per year increase. Do we know what it was before the cap came in, like the previous ten years before the cap?

MR. LISK: If you go back to 1987 or so, there were about 80,000 residents. A lot of subspecialty programs at that point have developed since then. Hospitals expanded the number of subspecialty programs that came into place that were recognized by ACGME. And so if you think about the number, it grew through about probably 1994, 1995 substantially. The slope was even steeper. And we can provide you a graph that goes back to 1984, for instance. We have a graph that could go back to 1984 that can show these numbers and the trends and we would be happy to share that with you.

DR. BORMAN: One other factor that I would mention that particularly 2003 and beyond, but some of it in anticipation of that, was the uniform requirements about resident working environment related to work hour standards and that programs that were able to expand did indeed do that to some extent because there was a certain amount of that that could either not be filled by mid-level providers with regards to skill set, and even for the functions that could be, that there were not an innumerable number of those individuals to bring into the system. So that is a factor in some of that, as well.

MR. HACKBARTH: Any other clarifications?

Okay. Now let's turn to round two. Inasmuch as we have spent a fair amount of time on this topic, I hope as we go through round two, people will feel the need to say if they have some concerns, express those, but also express what they are in favor of and what they would like us to be moving towards on this.

Let me offer my own perspective as a starting point. This is a really complicated area and it's hard to know exactly the right thing to do. I grant you that. On the other hand, it seems pretty clear to me that we've got a training system that is not producing what society needs and -- and this is the really important part -- it doesn't seem to be self-correcting, which to me cries out for some policy intervention. Feel free to disagree with that assessment in your comments, but if you agree that the system is sort of on a wrong track and isn't self-correcting, what do you think needs to be done about it? It is time for us to really focus in on what we are going to do.

So let me see hands for round two comments, and we'll start with Karen.

DR. BORMAN: To just quickly say a few concerns.

One is, again, what is the delivery system model that we're targeting this activity toward.

Number two, the concern that we have to be careful not to try and fix everything we want to do through GME.

The third thing would be that it's important that we avoid meddling at the level of specifying faculty, curriculum, admission criteria, whatever it may be.

However, there are some things that I think are areas that we can consider. Number one, I think a fairly simple issue is to try and look at the regulatory issues about ambulatory care training sites and the funding barriers to doing that, I think, and we should combine that with rewarding or incenting ambulatory environments with high care systems or high performance -- or high value providers or high performance systems would be ways to take us in a direction simultaneously and give us some metrics towards doing that, not just sort of blanketly throwing money out there.

A somewhat similar thing in terms of the NHSC, I think we know from the fact that there aren't more takers to it that the level of debt forgiveness is probably not attracting people relative to the debt burden that the

average resident is finishing with now, which is on the size of a substantial mortgage, for example, just as a comparison, even in today's mortgage standards.

So I think one of the messages is that we're probably not offering sufficient debt forgiveness and that we need to revisit that and we need to again try and incent that we put people in underserved environments that are also ones that start to take on the characteristics of high performing systems and efficient providers, and that that would be good investments of ways that we could go.

I would like us to be careful about the statement about admission criteria too narrow. That sounds to me a lot like meddling with curriculum. As somebody who has sat on more than one medical school's admission committee, I can tell you that a fair amount of material comes forward about other than their academic record in terms of straight gradepoint and MCAT scores and all that other kind of thing. So I think we need to be a little bit careful on that topic.

And the favorite thing that we've talked about, about the importance of organic chemistry, I would just point out to you that I think that that is a bit of a proxy for general scientific and thinking aptitude. I agree with

you, I don't use the Krebs cycle in every day of my work, but the thought processes and the scientific aptitude that it measures are helpful and I think we just want to be a little bit careful about what we label as unnecessary.

And then the part about costs -- and this is my last point -- would be that I'm not sure, Craig, and you can help me here, that we've done this cost reporting and so forth. We're not really capturing some of the other educational costs like simulation laboratories, for example, or team training laboratories. We don't capture that.

MR. LISK: When we're looking at the IME adjustment, in terms of to the extent that contributes to higher patient care costs, it would be reflected in that. To the extent that it is put in as a direct GME cost, we are capturing it. We have not taken a detailed look at the direct GME costs and payments.

DR. BORMAN: I mean, one of my concerns here is that there is an increment -- you know, we can talk about, and Peter referred to what is the percentage we're talking about. I have some concern that modern educational expenses, some of them which are very pricey and that we like in terms of simulation, which enhances patient safety

and team training and some of those things, are expenses that we don't capture as part of the cost of education and that as we look at adjusting formulas or percentages, that we should try and get that, and that is partly because the money is so untrackable, and that if we move forward with considering moving some of the money to some control of the residency programs, that the first step is making some of the money more trackable. You know, in order to move it to the residency programs, it would need to start to be trackable dollars, or if we left it residing with the sponsoring institution, that we specify that a portion of it become more specifically trackable relative to faculty or other things that we want to incent. So there may be some middle ground about how to do that.

And then, finally, on a longer-term strategic level, should be readdressing the formula, that is, the intern-to-resident bed ratio in am ambulatory-driven environment starts to sound like an enormous anachronism and there's lots of talent that could be brought to bear about what formula we should be thinking about, as do we need to go there ultimately.

DR. CASTELLANOS: Thank you. Just to emphasize

one of Karen's points, I think that the greatest opportunity we have to influence this is through a payment policy and perhaps a look at how it's being paid now on a hospital admission bed basis is not the way we want to do it, but perhaps link it to some factor, to include ambulatory or outpatient care.

And the second issue on page seven is, again, or slide 7, I really think before we make a lot -- and maybe we're a little late on this -- could you turn to slide 7, please? Maybe we're a little late on this, but one of our goals is to produce a workforce that serves the needs of our society, both today and tomorrow, and I don't see that we've really looked into that. Today, we have looked at it. We've looked at shortage of primary care. We've looked at some of the specialty, perhaps. But, you know, thinking about system reform and the ACO models, et cetera, we need to kind of think in the future a little bit and I don't see that we have looked at that and I don't see any data, or at least that I've found, that gives us any credence about some of the recommendations we're making.

DR. CHERNEW: I'm still unclear in the chapter and then in your comment when you talk about the studies that

demonstrate the impact of some of these particular things, about how well those studies were done and how well we really know. What I'm worried about -- so in the spirit of Glenn's comment, I do believe there's some problem that we have recognized that is real, although I don't think that I'm expert enough to know the nuances of that problem. But I'm very concerned that our response to the problem will be to start throwing money or things in sort of ways where we don't really have a good idea of what the magnitudes of the response will be. And so any insights you have as to what those magnitudes are and how much money it takes to overcome some incredibly strong incentives that exist in the system and how much money it would necessarily take in what places to do that would be really useful.

MS. BOCCUTI: I think, you know, not a lot of studies do sensitivity analyses that would sort of get to how much or what I think you're saying, and the ones that come to mind first are more about just income issues, and that relates a little bit more to fee schedule payments rather than GME monies.

So I think now that I understand more your question about how you would regulate the amounts, depending

on how much response you're hoping to get, I can't think of a lot that have been that regimented. But we'll look a little further and make sure you have the ability to look at these studies and make sort of an assessment about them. But I'm not even sure how much we want to go there, and I think maybe Glenn wants to discuss that.

MR. HACKBARTH: Just a clarification. Is your question specifically about the factors influencing specialty mix? It was framed broadly.

DR. CHERNEW: I think that you asked, and I think there will be some set of recommendations that will arise, and I think there have been a series of strategies for decades about how to make changes in physician workforce. And what I'm concerned about is that directionally, it will be something that we think is good. But our ability to do any sort of decent policy analysis about the costs and benefits of any particular recommendation will be extremely hard unless the literature is better than I think the literature is, and that's what I'm worried about.

MR. HACKBARTH: Yes. Karen, did you want to --

DR. BORMAN: Yes. I think the literature, Mike, is incredibly poor, and there's not even great literature

that assesses that trend that you saw about the increasing specialization.

And to just briefly comment, everybody has the sense that it's primarily about the money, and just to give you a preview of some work that I'm involved with, actually, out of 12 factors that we asked all finishing general surgery chief residents, all of them last year, money was number eight out of 12 factors -- income, anticipated increased income. And there were things far ahead of that that were the nature of the work and the operations, and even higher than that, ability to master a specific area. And whether that represents a generational thing about getting in control of a body of information or something that relates to a high-tech environment or something, I don't know, but income was number eight of 12 on the list.

MR. GEORGE MILLER: This is a fascinating discussion and I'm enjoying listening to it. Let me approach this from a different perspective. On page 11 of the reading material, we talk about having graduates who value community health, quote-unquote, and I want to correlate that with disparities and how do we address that issue. I would agree that we shouldn't throw money at a

problem, but there are some societal problems and ills that we need to address and can we address it through GME payments is a policy issue. I would think, at least in my mind, dealing with the disparity issue is one that's a laudable goal, and it seems to me that you would deal with that in the beginning of the educational process for medical students so we don't have the disparities that we currently see, and I think those disparities are well documented. At least, they are in my mind from what I've read.

So I just -- the question as we try to reform this through some type of recommendations, can we and will we address the disparity issue in that discussion if one of the goals is to create a community value and community health value in that process. So I just want to throw that out as a consideration as we deliberate.

MR. HACKBARTH: The principal mechanism right now for addressing disparities is through the Public Health Service Act and Title VII.

MS. BOCCUTI: I want to be fair to teaching hospitals and medical schools. They are doing some programs on these issues. There are reports that AAMC has -- they have missions for this. So I don't want to say that they

aren't, to be very fair. But in terms of Federal dollars, those programs are the ones I come up with as the largest. There are certainly others.

MR. HACKBARTH: Yes, good point. Good point.

DR. MILSTEIN: First, we know that the value of the educational output today is not a good fit with society's needs or the needs of Medicare beneficiaries or the goal of sustainability of the Medicare program. That was referred to in the testimony that we heard, what was it, last spring. And then the staff took the trouble of actually reading the RAND audit report and essentially matching up the content of what's going on in residency programs versus a reasonable portrayal of society's needs and it's not a pretty picture. And admirably, the representative from ACGME admitted that the overall grade nationally would be, I think he said C or C-minus or D, I can't remember, but it was not an honor grade. So we know that.

Now, the question is, well, what solutions do we put -- what are the broad -- and I think from my point of view, there are really two ways of going at this and they could be, I think, hooked together. One is to essentially

say, look, it is really hard for the government to essentially tell teaching institutions what to teach, disappointing as the audit results are, but let's at least make sure that -- disappointed as we are with the content, at least we're paying what it costs an efficient institution to deliver today's content.

Mark has warned, be prepared to be disappointed about our ability to differentiate efficient teaching function, as we last year in our report to Congress differentiated different hospital performance on value. But to the degree we can do that, that represents an option. Let's begin to gear how much we pay to what an efficient producer of medical education is achieving. That's not my preferred path, but it's a less ambitious path. Typically, there's a correlation between less ambitious and more politically feasible. So that's Path A.

And then Path B is we go -- we take that vision that we've carried through all of our other discussions, which is value, we want to increase the value of the health care system to American society and the value of the Medicare benefit to Medicare beneficiaries. We say we want to go after both content and the cost of -- both the result,

the output and the efficiency with which that result is achieved.

I think that tilts us in the direction of teaching institutions as accountable care organizations that for the first time have a clue as to how they're doing on both outcomes and process measures of quality and total health insurance fuel burn per person per year, which is what our measure of cost efficiency, because right now, these teaching programs are operating really in a vacuum on how they're doing on those two fundamental dimensions of value, and through participation in some reasonably robust vision of an accountable care organization, A, they would begin to get some clue as to how they benchmark compared to other educational institutions in producing the product that society desires, which is presumably a very nice environment in which to teach new doctors, and also I would hope in whatever version of accountable care organizations begins to take shape they would also begin to be held accountable not just for knowing what their scores are, but for bringing their scores up near the top, and that obviously would have very favorable ramifications for the content of what is being taught to health care professionals, be they medical

residents and/or others that we may want to address in a broader reform.

DR. KANE: First, I just want to say, as a member of an administration and a faculty of a school of public health that I'm getting ready to change our status to a medical school so that we can sort of sign up to have all of our costs recognized in some kind of a business that pays for all of our costs --

[Laughter.]

DR. KANE: But that is sort of the conversation I'm hearing a little bit, and I'm envious, but I'm also a little worried because the Medicare Trust Fund is what pays for this and I do think we need to articulate a little bit of a political philosophy about what is the Trust Fund's obligation to pay for everything it takes to educate a doctor, keeping in mind there are other sources out there and Medicare does -- and the individuals take on some of the costs of that and then they get it back when we pay their fees and help them make nice incomes in the range of, you know, three to five times that of the average person paying into the Medicare Trust Fund.

So just in terms of if you go too crazy about the

Medicare role and intervening in paying for everything, I think you end up kind of making it even more inequitable in the whole way of whose education gets paid for and through what means.

But that aside, this chart, I have a couple of reactions to it. One is on the demos and favoring ACOs. Maybe I'm just still warped by being in Boston, but my feeling is the ACOs, or the academic health centers are in many ways already in the best position to be ACOs and the community hospitals are often less advantaged. I mean, it sort of depends, obviously, market by market.

But I would be a little concerned about any favorability of handing out demo funds to ACOs unless they had a lot of community hospital involvement in that. I really think you can't help one group of competitors get an infrastructure and leave the other competitors to fend for themselves. So you do worry about favoring the academic hospitals in developing that infrastructure for an ACO over the rest of the hospitals that are in the marketplace, as long as we have competitive markets, anyway.

And then the other thing that I thought of is where that extra -- I am just so excited that there is all

this extra money out there that I would like to see great ways to spend it. But the VA is a national resource and a real treasure and it plays a huge educational role. I think almost every doctor goes through there for some period of time. Perhaps -- it's not on our list there, but I know -- I mean, I'm pretty sure that many, if not most, residents go through the VA for some stint of their care. The VA is a pretty advanced delivery system that has a lot of ACO features and could there be some way to work with the VA to develop a competency, you know, make explicit competencies that every resident would achieve around being a team member, care coordination, learning how to use an EMR, learning how to use registries and stay in touch with things that are going on about chronic care management programs, whatever it is.

But that the VA, because it touches so many residents, it is a Federal -- I mean, it is a national resource, maybe a better way to think about how to make sure everybody gets those competencies is to think about -- or one way, anyway, is to think about how to get the VA to be more explicit about what it trains all residents to do in these kind of reform skills that we're wanting all residents

to do. Just a thought, but they are very well organized to train people in these new kind of integrated and accountable care type skills.

MR. HACKBARTH: It might be helpful, Cristina, just to remind people of the size of the boxes, how many dollars are in the boxes.

MS. BOCCUTI: Sure. From Craig's calculations, roughly, from the work that he has done, it is about $3 billion in each box. So there are about equal shares for this. Does that answer enough of your question? This is for 2008. That was the estimate for 2008.

DR. BERENSON: First, I want to briefly disagree with Karen about organic chemistry to make a point about what our purview should be. I should have flunked organic chemistry. I only passed because the professor decided to grade on a curve and give my completely unsuccessful performance a passing grade. I would not have gotten into medical school today. I think this notion that you have to have this scientific aptitude is misplaced, but the point is, I don't think the world would benefit if Karen and I argued this out and MedPAC adjudicated over our different views of the role of the scientific aptitude.

[Laughter.]

DR. BERENSON: I think we are sort of getting into territory that is not ours. So that makes me a little nervous. I think we have to be very concrete and specific about GME funding, which is a Medicare issue.

Having said that, I do think, because MedPAC is influential, is looking out for 44 million Medicare beneficiaries, I think we can be clear about the deficiencies that we see in the current workforce and how it doesn't well serve Medicare beneficiaries, and then participate at meetings in testimony, but leave the specific policy prescriptions to others who have more direct knowledge or jurisdiction on those particular issues unless something just pops up that we think there's a really opportunity for us to be decisive. So I think I'm trying to say, we can look at the whole breadth of this, but our focus on specific policy recommendations should be about GME.

I wanted to go to the ACO one. I'm a little concerned that we don't really know what an ACO is. I'd be interested in, I mean, looking at -- there's a lot of medical training programs in California. They, in some ways, have been living in a world at least where they're

accountable for costs and perhaps for quality with recent initiatives by IHA and others out there. I'd be interested to know whether the nature of medical education is affected at all by being in that kind of an environment. I'm not sure. I think we might be having too great expectations on creating a structure called an ACO, that it will dramatically impact the sort of quality of medical education. Maybe we could help contribute to that, but I think just sort of laying out an ACO criteria and then differentiating payment makes me a little worried.

DR. MARK MILLER: In some ways, I think this picture is an attempt to bring together some of the thoughts that you've just articulated here. One of the things to think about here is whether you want to take the current GME funding, which is divided into three boxes on this graph, and devote it to other objectives and have it spend out in different ways.

So while at the top it says demos, and it says ACOs in parentheses, I think some of the thought there is if the academic teaching facility was willing to be first in a demonstration -- whether it's ACOs, bundling, whatever the case may be -- would some money be linked to that?

The second box is to say -- and this has been raised by many people, and I think raised by Karen again -- whether the money goes to the hospital or to the program. And we can talk through a bit of that.

And then the third piece is sort of -- well, the money wouldn't -- would go back to the Treasury. And then the idea is general revenue would be boosted to go to some of these other programs to deal with some of the front end pipeline issues that some people raised.

The reason I raised it at this juncture is Bob was saying you should be focused on GME and making decisions out of that. What I want to be clear is that's the GME money. You could still think about how to devote it to some of your objectives.

I'm just trying to pull that together.

MR. HACKBARTH: Thanks, Mark. That's helpful.

And so focusing on the ACO piece, the notion there is that we would respect that we don't have the expertise to redesign the curriculum and all that. The issue being raised is should we take a piece of the Medicare money already being invested in medical education -- it's not new money -- and say, well, let's condition this on the

institution's willingness to invest in a 21st century environment. And then there are all sorts of questions about how well we can define that and who qualifies for the money. And then there's Bob's ultimate question, will that actually alter behavior.

It seems to me that it would be good if we could go to some places, whether there's any literature on places about whether medical education differs in environments that we perceive to be different. Is it different at the Mayo Clinic or is it different at Kaiser Permanente? Has there been literature on that?

DR. CROSSON: Well, I can answer that. So just in terms of that, yes. We have about 400 residents in California, in our hospitals in Southern California -- Northern California. If you line up the issues in terms of kind of like where are these gaps between what residency programs or the whole pipeline is producing versus what society needs, I think in some areas, we are able to address those.

For example, the issue of not producing enough generalists, I think we have, because of the needs of our program, the nature of our program, we obviously have

focused on that and I think we've probably done a pretty good job in that area.

In terms of the issue of diversity, I don't know that we've done much better than anybody else because it's affected by what is available. We do have outreach programs, but I wouldn't maintain that there's anything special about our organization that has enabled us to do that as well as it might be done.

And I think in the area of geographic access, of course, it's kind of irrelevant because we're focused mainly on where we're in business, and mostly that's not in rural areas.

But in the fourth area, I think, which is to try to produce individuals who are equipped for 21st century medicine, you know, for example, to be willing to practice medicine in a transparent environment, be comfortable with that, to practice medicine with an inherent idea that there is some responsibility for the cost that is generated by the pattern of decision making, those areas, I think, we have been successful.

MR. HACKBARTH: If we can, in our chapter, try to address this link in the argument, if you try to create the

incentive, will it make a difference, that would be helpful.

MS. BOCCUTI: I'll mention that we're going to try and look at some places that deal, in particular, with non-hospital training and sort of get some ideas of ways that they overcome some barriers and really support non-hospital training, and we're going to try and look at places that aren't necessarily the Mayos that you talk about because there are all sorts of other issues that make them stellar examples. So we'll be able to get back with you later in the spring on some of our findings with regard to that.

MR. HACKBARTH: Jay, did you have a question?

DR. CROSSON: Yes, and I'll shorten it because I just made a few of the points. But I think the first thing I'd just like to reiterate from the presentation is that there is a problem here, and as I just said, there does appear to be a gap between what's being produced and what we think society needs.

Now, I think everybody can argue with some details around that, but I do think that there does appear to be a disproportion right now between the apparent growing importance of competent generalists and the flow of medical students into those careers. Now, I know, Bill, the GAO

says that's being currently replaced with foreign medical graduates and could be replaced with other practitioners, and I'm not discounting that. But I do think that we don't know for sure that going into the future, that it will always be satisfactorily replaced with foreign medical graduates and I think there's probably some natural limitation to the capabilities of other than physicians.

So I'm not comfortable saying that just because the data shows that up to this point, those slots have been filled with foreign medical graduates, that we can necessarily say, therefore, it's okay to have a policy which says we're not going to deal with this situation that is disincenting American medical students from going into generalism.

I think we talked about the other values -- diversity, geographic access, and capacity or capability to practice in the 21st century. I like slide 13 because I think what it basically points out, not to be terribly reductionist, is that as Bob was saying, this is a Medicare Commission and so we have to look at what tools we have and what we might be able to use to influence that, recognizing that I don't think we can expect to do it all by ourselves

or that we have the expertise to know exactly what to do. But we do have this one tool. It is that black box that says "extra."

It's a tool we've reached for before when we made the recommendation of reducing by one percentage point that box and we suggested that, at the time, as I remember, that that money be transferred into paying for value. We thought that there was a -- this tool was a legitimate tool for us to use to try to further other ends that we thought needed to be furthered, and I think this suggestion is along those lines.

And what I read it is -- as I read that, those arrows there, is not let's just take that money and dump it into ACOs or dump it into a question of how the training ought to be organized at facilities and how the money should flow, or for that matter, just return it to the Federal Treasury and hope that it's put into Title VII and/or Title VIII, but that we could say we're going to take a leadership position on the part of MedPAC. We do have this tool, and we want to work with others, whether it's other branches of the government, whether it's the VA system, whether it's private payers or other ways of extending the base of

funding for medical education, we want to work with others using this tool and we're going to try to advance it along these parameters.

DR. SCANLON: First, I guess, close to this point, in terms of understanding this chart, I mean, I think that -- I may have misheard you, Glenn, but I don't think we want to say that we're taking -- if we were to move this money that's in the "extra" box, that we're taking money from graduate medical education, because what our work has shown is that this is money that is not being -- and these are not costs of graduate medical education.

MR. HACKBARTH: Right.

DR. SCANLON: And so it's money that we're, in some respects, overpaying.

At the same time, the residents' cost box, we don't cover the full cost of the direct medical education, and that's something where the hospitals do put in sort of additional funds. Now, that does not concern me, in part, because the hospital is making an economic decision and it is beneficial to them to have a residency program and their private insurers and other payers are paying for this, even though it may seem indirect, because it's built into the

overall cost. And so, again, so I'm not worried about that, but I think it's -- we shouldn't ever be accused that we're shortchanging medical education if we were to move some of this money.

Two other points. One is about sort of the Title VII and the National Service Corps and those kinds of programs. Yes, I think they are effective in terms of accomplishing some of the goals with respect to diversity and getting people into rural areas, but I think we need to look at them from the perspective of how can we make them more efficient? And historically, they have not all been equal in terms of sort of the retention rates, in terms of people that participate in the programs and in fulfilling obligations, or even willing to sort of stay there for your obligation. There are people who just will take the money and say, I'll pay the penalty. I want out of this because this is not acceptable to me. So how do we find ways to reorganize those programs to make them as effective as we possibly can?

The other point is about, sort of, I guess, kind of a general reaction to the recommendations, which would be let's not prematurely lock ourselves into recommendations

about graduate medical education or medical education more generally without understanding better sort of what the needs of the workforce are for the future, because I think that it's much bigger than physicians. It's much bigger than, in some respects, the current professions we have.

I'd refer everybody to the article in the Journal of the American Medical Association yesterday by Bob Brook talking about how you can think about different types of personnel doing sort of different sort of functions, and I think that has very significant implications for medical education. It has very significant implications for the projections that we have of the workforce going forward in the future.

And in terms of generalists, Jay, I understand your concerns, but I also sort of feel that until we define a world where we really understand what we want a physician to do, it's hard to say what we want a generalist physician to do. I can see in some ways tasks that are right now the norm for a generalist physician being given to others. And even some of the new tasks that we're talking about for a generalist, this idea of coordination and counseling.

I have real concerns about whether or not all of

that science education, all of that sort of medical education, is really the right preparation for coordination and counseling, and when we say we should add that to residency programs, I'm still questioning myself, why did I make this big front-end investment on things that are not being used sort of extensively in the activity? It is not that someone who is engaged in coordination shouldn't be able to draw upon a physician or counseling, but it may not be that I need somebody that -- I mean, essentially, that expensive, that knowledgeable, to do that function on a regular basis.

So I think we really need to start to think about sort of what are the tasks and what are the occupations that should exist to best match the tasks that we have for the future.

MR. BERTKO: Okay. I'll try to knit a couple things together and be a little simpler.

First, Cristina, I want to show support for this diagram on slide 13. I think it's a good way to think about it. And following both Jay's comments and Bill's, I've interpreted that the box that says "extra" as being designated not so much to support an ACO or a medical home

or anything, but to support the training for the skills that would be useful there. I had a couple of them, maybe to follow Jay's and Bill, some of the care coordination types of training, use of HIT and EMRs, and following budgets, learning how to do budgets and that cost awareness that I think Jay mentioned.

So now we give you the hard part of writing a recommendation that wraps all these things up, but I would like to say that sounds like the right direction to head.

MR. HACKBARTH: Let me just pick up on that, because I think this is an important issue. One notion about this is to try to identify the skills that are needed to practice 21st century medicine and specifically reward those. Logically, that entails somebody saying, here is the list. Here is the curriculum for the 21st century physician and the Federal Government is going to buy these curricular elements.

An alternative approach is to say, that may be not the right thing for at least MedPAC to be doing. Maybe that's something that ACGME and others ought to be doing, but that's not really MedPAC's bailiwick. But maybe we can support that by saying, if we encourage teaching

institutions, or at least some of them, to themselves reorganize to be places that demonstrate, exhibit the characteristics of high-value providers, that will create an overall environment for training that is better than exists today. So it is an indirect approach.

What I had in mind about this is we're doing the second. We're not doing the curricular approach and saying, here is what we're trying to pay for with this extra money. Instead, what we would be trying to do is use the money to encourage at least some teaching institutions to evolve towards high-value providers.

Now, there are the questions about whether that will alter the content of medical education and whether that indirect approach will be effective. But that's what I have in mind.

MR. BERTKO: And I would respond, Glenn, I am open to either way, and the way we've done it sometimes, if you took that second approach with a more indirect way, I would hope that the discussion underneath it could then say we think the kind of -- these four, five, ten kinds of skills are the ones that should be built into that indirect approach.

MR. HACKBARTH: Yes.

MS. HANSEN: I think the areas that I had really have been covered relative, especially, to the last couple of discussions about what are the outputs that we're really looking for for the 21st century aspects. And then one is the disciplines as we've known them versus the disciplines that may evolve and may actually look quite differently. Just as some people are doing skills now or treatments now, say we were talking about doing sigmoidoscopies that are necessarily not done by physicians but perhaps advanced trained clinicians, and we need to begin to think about the needs of the population as compared to the structures that are traditionally there.

So however we do this indirectly. We've talked about this before. I've actually brought up, and maybe this is more moot now, but even the knowledge of how to deal with the interface of comorbidities and polypharmacy, which is reflective of where the population is going. So however we get to the competency of producing the skills, and not by prescribing curriculum but the outputs, that is what I would look for.

I mentioned earlier this morning, too, the point

of both -- two things. One is what is happening in other disciplines and also with Title VII, Title VIII and the Service Corps. The first one, on the discipline, right now, there is an ongoing, or just recently started initiative at IOM about where the future of nursing is going, and this is a very close companion piece to really thinking about where the future of the disciplines is. So I hope we -- and I talked to Cristina about it and Craig briefly, just to make sure we knew what was happening on that side, coupled with what's happening in legislation right now. There is in the Senate Finance bill things that relate to graduate nurse education, so instead of GME, but it's, again, about dealing with a comorbid population. So there's something happening.

And then finally to the point of the current programs that seem to produce the most, at least, placement and continuation of people in areas such as community clinics or rural areas, if that has shown to be effective, and I think to Bill's point, can we make them more effective, because we know that that does produce the traction of where needs will occur, so perhaps whether or not we refunnel the money or part of the money toward these other programs, which I know is very tough, but it's just

like that's where the production will start, it may be a consideration.

And then, finally, I think others have brought this up and I want to emphasize this again, since not all care will be in hospital institutions, how we relook at that in terms of the distribution of that kind of funding in the future with GME funding.

MR. BUTLER: First of all, Cristina, thanks for the opening remarks that at least GME is a pretty popular product in the fact that an awful lot of international medical grads certainly want to come here and we don't send as many people to other parts of the world for graduate medical education. So at least it's a popular product and, I think, does a lot of good things beyond the issues we're discussing today.

I also said last month that I like to start with what do we want out of this and line up the money last. So we've been focusing on a chart that lines up the money. Having said that, I find this a very helpful framework with which to make my comments, so it really does help to see where we should be focusing. So let me make my remarks in that context.

If you look below the line, the direct GME, that really was an obligation of the Medicare program when it started. We're going to pay for our share of the graduate medical education cost. Above the line came about when DRGs happened because trying to level the playing field to look at the collateral cost impact of having residents. And that was a convenient -- not a convenient, a statistically-driven number that may have been too high or is too high and certainly is too high now if that's what you're trying to capture. So they're a little different, the origin of these. And for some of those reasons, tinkering with the bottom half of this is a little bit harder to do with a little bit less yield to me, in general, of where we ought to be focusing our efforts.

And let me say that in yet another way. I think we have about two percent of the Medicare budget tied up in this chart, $9 billion when you take all three, right? And two-thirds is above the thing. And you say, Nancy, regardless of how much we commit here, the newly-minted resident or fellow and how they practice lifelong has a far greater impact on the sustainability of the Medicare program than these dollars, and that's where the real energy needs

to go.

Now let me back up on the bottom half of the chart, if I could, for a minute. I do think we could comment on some things like caps, for example, acknowledge that the full costs aren't covered, that, in fact, if there are new slots that are to be given out as health reform legislation says, maybe they ought to be given to primary care. We certainly shouldn't make the number of positions available a barrier to the primary care, so to the extent that that helps.

But we know that incentivizing institutions, whether it is reducing down to 50 percent the payment or even if you went 150 percent to offer more slots in primary care, I don't think that it's going to solve it, because it's not the institutional incentive. It's the individual physician who's picking the specialty that needs to be incentivized, either through higher primary care payments or, in fact, through loan forgiveness kinds of programs. If they're significant enough, it would have a direct impact.

So I think that we can comment on caps, but I don't think we're going to make major contributions, unique contributions as a Commission on the bottom half of the

chart.

So now let's go to the top half of the chart, and I think, Glenn, you're hearing a consensus around the curriculum issues versus the training environment. At least, that's what I'm hearing, and I would reinforce that definitely as being the area of focus.

So I think where we're a bit -- and this is kind of my passion -- how do you create a kind of meaningful user kind of concept in a delivering environment that says you've got to earn up to the -- if you can demonstrate that, then you can earn your IME dollars, if you will. How do we create that menu? And I do think that it's a little simplistic to just put ACOs up there, because it does beg then Nancy's issue, are they getting subsidies that others aren't. I don't think it should be tied specifically to that.

Having said that, I would say that there are things like the AAMC's effort to advance Health Innovation Zones, which is a comparable concept, are things we would want to incentivize, but I don't think that simply you get money for ACOs and others don't. I agree with that. So I think we need a little bit more robust list of what that

environment looks like and how we might do that.

I think the beauty of what we're doing here is you could take all of our health reform chapters -- bundled payment, medical homes -- I mean, this is our sweet spot. This is where we've tried to define the system of the future already and we're trying to just line up dollars in this area that may be supportive and reinforce that. So I think it is what we do, and I think we could say this is where things are heading and we need to incentivize that to occur.

My last comment would be on the residency program, and I think what you mean by this is would you give money directly to residency programs versus institutions. I do feel pretty strongly about this not being a good idea for a couple of reasons. I'm not saying there shouldn't be exceptions, but if you think about we're trying to create coordinated care across systems, this does just the opposite. It puts them in silos. And even though I understand the need to focus on primary care and family medicine, if we send money directly there, you know, what is the message we're sending?

I think that, for example, having psychiatrists work with family practice or internal medicine to know how

to understand the management of mental health, or having cardiologists partner with internists and family practice to handle congestive heart failure or readmissions, the multidisciplinary dialogue and education that has to occur could somewhat be hurt by sending money directly to individual programs as opposed to institutions of care. So I have concerns about that.

The other concern about it is simply that if we follow our principles and send money directly to some of these sites and base it on the percentage of Medicare, the percentage of Medicare in some of these sites is often low, and if they're expected to also have the costs of the program borne, the economics don't work very well and it becomes logistically pretty tough to have some of these sites say, okay, we'll do this.

So obviously I'm a little bit concerned about separate payments directly to programs because I think it runs counter to our systems of care that we're trying to create and reinforce in what we're doing overall.

MR. KUHN: I think the discussion on this has really been terrific, and the notion that I've heard from some of the other folks so far is the issue of the

interdependencies here, that this program and all the programs we've been talking about go together. So the fact that as we look at this and we're thinking about how is the alignment of this with the other things that the Commission has recommended or things where we want to see health care go is absolutely critical. And so maintaining that alignment, maintaining and having the full understanding of those interdependencies is going to be critical for us as we go forward.

So having said that, when I look at this, as I look at other parts of the Medicare program, I think of it as a series of signals and tools. And when you think about signals, the issue is here, as kind of Peter said, what do we want? And Glenn, I think, nailed it when he said what we all want is high-value providers, period. End of story.

So how does this particular program help us kind of do that and move that forward, and how are we able to get what we want to pay for out of our medical education in terms of making sure that we have training with multidisciplinary teams, that we have folks that are training that are looking at IT, but above all else, that we're looking at physicians who are coming out of the system

who really understand the issue of cost effectiveness in terms of the delivery of care, and that has to be absolutely critical to that.

So I think the signals are pretty clear, what we want to do, to me as we go forward here. The real question, then, is what are the tools that we have to deploy and how do we use those?

And I agree a little bit with, I think it was what Karen said earlier, is that I don't think we want to meddle in the accreditation area, but I think we can articulate a set of core competencies that we think ought to be part of this process as we go forward and I think that makes a lot of sense. And then how do those core competencies translate into maybe new delivery models?

I think the ACO is a good one that ought to be incentivized, and we ought to try to move that. But there might be others that are out there, because I think at the end of the day, the hypothesis that we all have is that if this is the way physicians are trained in the future, then when they come out of school, these are perhaps the new delivery systems they'll want to practice in and will hopefully look for those. I mean, at least that's the

hypothesis I'm going on.

So the fact that we can look at both core competencies and then perhaps, I think as Peter said, and I agree with him, look at maybe a menu of options of how that could be done through delivery systems, of which ACOs is one, might be a good way for us to think about this on recommendations.

MS. BEHROOZI: Yes, I like the way both of you, Glenn and Peter, talked about the characteristics of the institution and the environment. In a way, I feel like we're almost looking for a new way to justify, empirically justify some more IME costs, kind of. So I think Peter said, or used the phrase, a more robust list of what comprises the environment.

What I'd like to add to that, or my take on that isn't just the environment for training physicians, because we're talking about the workforce for the future, and in the paper you spent -- and actually, in the presentation you also spent some time talking about non-physician providers and some of the attitudes that physicians will need to have, not just the things that they need to learn in an academic way. So some of the things that I would put on the list

would include whether the institution has a robust program for training non-physicians, whether R.N. or physician assistant or other kinds of medical practitioner parts of teams, non-hospital experience, which you've adequately -- more than adequately -- discussed.

One of the things, actually, that we had talked about in a much earlier session on this, last year, I guess, was the rather dismal proportion of institutions that are training doctors that are not wired, that don't have robust IT systems, and that's the kind of thing that clearly takes some money to implement and ought to be recognized as an essential part of a good training environment.

And going to George's point about the same line I underlined, educating and graduating students who value community health, yes, people who are from low socio-economic backgrounds or of a different ethnicity than the majority, whether African American or immigrants or whatever, are, yes, innately more predisposed to work with underserved populations. But they're never going to comprise the majority of physicians, or not for a long time, and it's absolutely essential to diversify the ranks of physicians, but it's also essential to make sure that all

physicians, whatever their own ethnicity or their own background, are able to care for the range of patients who need their care. You know, you can't be -- you shouldn't be able to be selective about who your patients are and how you treat them.

So what does that mean in the context of medical education? Well, to avoid being prescriptive about having courses in diversity and tolerance and all of that stuff, maybe it's worth looking at the patient population that the institution serves, and I wonder if there's literature showing that people who are training in institutions that are in low socio-economic demographic areas, obviously high Medicaid proportions, whatever, are more likely to serve underserved patients no matter what their own race or ethnicity or socio-economic status is, if they're more likely to serve the underserved than people who practice in more elite, if you want to call it, institutions. So I think that might be something to put on the list.

MS. BOCCUTI: I'm not sure if there's real research on that, but we should note that teaching hospitals in general are more likely to treat these populations. So they are in there. I mean, Craig might want to speak to

that more, but we'll look into that kind of research.

DR. DEAN: Thank you. Obviously, this is a very interesting discussion and something that's near and dear to my heart. I'm especially concerned about the pipeline issues, but I also recognize that Medicare may well not have the tools that we really need to deal with that. I would really support the idea that maybe we need to somehow give additional support, whether it's moral support or dollar support or whatever, to the programs that really have a more direct impact, Title VII, National Service Corps, AHECs, those things, because they really do -- they've got experience and they have been shown to be effective.

With regard to the admissions issue, I also think that's a serious concern, and I'm certainly sympathetic to Karen's point. At the same time, the trends we see are not reassuring. We're getting fewer and fewer people from underserved areas and from minority groups and so forth and larger proportions of people that come from the majority population and elite colleges and so forth who are much less likely to respond to the needs of those groups.

And, by the way, I would add to the underserved groups, I think it would be worthwhile mentioning American

Indians, because they are probably the most underrepresented of all of the minority groups in the mix of incoming students.

To move on to the whole residency issue, where obviously Medicare does have some significant impact, I think we, first of all, need to say, I mean, why do we have residencies, and they really, as I see it, there's two functions: One, to staff the hospital, and one, to provide an educational experience. And it seems to me that it's very appropriate that Medicare should support the second and not necessarily the first, but unfortunately, I think we've done both over the years.

I'm very attracted to the idea that we should provide some sort of rewards or incentives to those programs that really have shown that they've taken the delivery system reform seriously and have provided their trainees with the tools to really function in a new delivery system and to function effectively.

I think that, especially with regard to primary care, one of the things that is -- we talk a lot about the inequities of payment, and those are clearly major issues, but I think those are not the only issues and I think,

again, Karen mentioned it when she talked about there's a lot of high-paying general surgery positions that are going unfilled for other reasons, and I think that's also true in primary care. And so I think if we're really going to deal with this shortage, we have to demonstrate to new trainees that you can do sophisticated, rewarding primary care in a modern environment that really makes use of the skills that you receive in your medical training.

And I would take issue a little bit with the whole idea that care coordination is just simply making sure that people get their appointments on time and so forth. In my experience, a lot of care coordination has to do with, I'm taking ten drugs and I don't want to take them and what am I going to do? I'm just going to stop them all. Well, we see that happening a lot, and that's a pretty high-level judgment. If we look at that list and you say, well, okay, there are some trade-offs here. We probably can do away with this one and this one, and if I cut this from ten to six, would you be willing to do that?

Or the cardiologist tells me to one thing and the endocrinologist tells me to do something different and I'm not going to do either one. That also is a fairly high-

level decision making, to negotiate what can we do that's least likely to get that patient, well, back in the hospital, to be very specific about it.

But the challenge is to -- and the focus of the medical home movement, which I would actually put, I think, right alongside ACO or maybe even above it, because in my mind, it's the medical home structure that really provides the tools to do these things. The ACO is a sort of financial structure that will take advantage of what a medical home can provide. But the goals of the folks that are really the evangelists for that structure are that we should have every professional working at the top of their license and that we need physicians, but we also need a range of other competencies and we need to make sure that the physicians there are not filling out authorizations for durable medical equipment or the other nonsense that we do spend a lot of time on and that turns a lot of current, today's primary care doctors -- leaves them frustrated and feeling that they're not doing anything significant. We've got to put the primary care physician back into a role where they really feel that they're doing something important, because we know there's an important job to be done, so I'll

stop.

MR. HACKBARTH: I think we've made some progress here. Jay is going to offer some comments on where he thinks he hears some consensus. But before he does that, I just want to sort of work on a different plane for a second and talk about issues that this framework addresses and what it doesn't address.

Let me start with the things that it would not address. So this would -- if we go with a framework like this and embellish it, tweak it, et cetera, we would not be explicitly addressing the issue of caps, you know, should Medicare fund training for more physicians. We wouldn't be taking a position on that one way or the other. That would be set aside.

A second thing that would be set aside and not addressed is the appropriate mix of specialties for Medicare to support in training. We would be agnostic on that.

A third is that we wouldn't take on issues about the appropriate curriculum, whether in undergraduate medical education or in graduate medical education. We wouldn't address that directly, but perhaps indirectly later on.

Another issue we wouldn't address is the overall

financing scheme for graduate medical education. The original idea was that Medicare would be joined by private payers and we would have a scheme where all of the people who benefit from the health care system contribute in explicit ways to financing this activity. There are still some people who would like to go down that road, but again, we wouldn't address that. We would be silent on that question.

By not addressing those issues, we would be avoiding some thorny thickets.

Now, what we would be beginning to address is how can we get better output for the Medicare dollars above the empirical amount. So the direct GME covers the direct costs of training and it's below the line. We're basically not talking about that. We're saying, it's appropriate for Medicare to pay some indirect medical education because there are costs beyond the direct that are legitimate and should be supported. But we've got this $3 billion that isn't in either of those categories, and we're not saying we ought to take it out of the system altogether, but we ought to redirect those dollars to get more value for the expenditure.

If we were -- one of the points of disagreement that came up was around the residency program piece of it. Karen, not so much today but in previous meetings, has raised the issue of why does all this money go into the hospital general fund and then the training programs need to go to the hospitals to get their activities funded. Some of our guest speakers have raised the same point.

And the idea here is, well, we could address that issue and say that at least some of this money is not going to flow through the hospital budget, but flow directly to training programs. Now, there are lots of important issues there about who would receive the money and what not that would have to be addressed, but that's potentially an area to get into.

I hear some disagreement. Peter has made a strong argument that that would not be a way to go, so we'd have some work to do, but that's an important issue possibly addressed.

Closely related to that is that one of the odd features of the current system, from my vantage point, is that all this money on the indirect side is linked to -- well, in fact, also on the direct side, it's linked to

Medicare volume. From a societal standpoint, I'm not sure that linking it to Medicare volume is a particularly rational way to deploy our resources. If we were to say we're going to take some of the indirect medical education above the empirical amount and start distributing it other ways that would no longer be tied to how many Medicare cases the hospital has, it could be tied to the ability of programs to develop rich ambulatory environments to train their physicians.

Then the last thing that we would address in this framework is that if society wants to address some of the pipeline issues about mix and diversity and where people choose to practice, probably the best vehicle for doing that is not through the Medicare program, but through the Public Health Service Act, and we could endorse that as a way to go and perhaps also say that, again, some of this money ought to be redirected to that channel.

So that's a sense of some of the thickets we would be avoiding, about specialty mix and caps, and some of the ones that we would be wading into and have to address down the road.

Jay, you had some thoughts about --

DR. CROSSON: So is this a softball across the plate or am I in the dirt?

[Laughter.]

MR. HACKBARTH: He's got all these wonderful notes. Just read them.

[Laughter.]

DR. CROSSON: So the notion is sort of where do we think the consensus is, and I think Glenn has spoken to some of that already, and what could we imagine as either something that we're going to write up or a set of recommendations or directions for future work. And I think my sense of it is I'm going to suggest something more to the latter as opposed to saying, gee, we're ready for some hard recommendations here.

But I think there are some things, for example, that I see sort of consensus on. The first one is that I think we've identified, and I think we can speak to the fact that there appears to be a gap between what the pipeline, if we want to call it that, is producing and what is needed in the future. Everybody has a slightly different idea about that, but I think in almost everybody's comments, there's been a recognition of that. And I think for the Commission

to say, we recognize this, and then to try to write down what we think some of those gaps are would be of value.

The second one is I think we have identified, and I heard pretty much consensus that we've identified that we have a tool, one tool that we could use to address this. So the larger problem is sort of physician manpower. We get reduced now to the residency program's or training program's impact on that because that's where we have this Medicare tool, which is paying for graduate medical education. Reducing further, we have this box which is called "extra" or overpayments, which we have previously identified as a tool that we might be able to use to resolve issues.

So we could, in fact, go on record and say, you know, by the way, we have this tool and we're not exactly sure right now how we want to employ that, but we do have an intention over time to try to understand better how we can employ that tool and we're pretty sure we want to do that.

And then the third part of it would be to engage the staff, at Mark's direction and the timing of that, would be to engage the staff in trying to understand better how we could use that tool to, in fact, work with other entities who have other ideas about this, and perhaps in some areas,

more expertise. I'm thinking about HRSA, AAMC, COGME, and others to say -- to answer some of the questions that Mike brought up. If we did this, if we doubled debt forgiveness in a certain way, what do you think would happen as a consequence of that, and is that the right direction to go in? How would we exactly target this money towards supporting 21st century training environments that would produce physicians who better meet society's needs?

I think we all have the sense that there's something there, but we probably would need to get a little bit better at what exactly that would entail. You know, how could we use some of that money to support the development of ancillary providers in ways that are maybe being used -- will be used differently than they've been used in the past.

So it would be essentially three parts, saying we recognize there's a gap between what's being produced and what's needed and here's some information about what that is. We've identified a tool that we intend to use to fix this. And we are open and, in fact, are going to be seeking out to work with other entities to try to figure out -- to get to specific recommendations about how we might employ that tool.

And the only other thing I'd say in the end -- and by the way, we're simultaneously as a Commission going to be doing other things, for example, looking at, as we will later, the issue of how physicians are paid and whether the payment formulas that we have now are the right ones, which may also have impacts on this question. So it's not that this is the only activity, but it's the activity that we've identified specifically to address this problem.

MR. HACKBARTH: Okay. Thank you, Jay. Thanks, Craig and Cristina. I think we're making progress.

MR. HACKBARTH: Our last session before lunch is on some case studies in metrics for high-performing systems, and David is going to offer a workplan, I guess.

MR. GLASS: Today, I'll describe a work plan we're proposing to look at what high-performance systems are doing to improve care coordination and efficiency and how Medicare might recognize which systems are high-performance.

The literature often cites certain integrated delivery systems, hospitals and group practices as high-performing. When you visit some of these systems, you walk away thinking that something real is going on. We spoke with nurses at one system, for example, who had worked

elsewhere and now don't plan to leave the current one. Before, they felt like number, interchangeable bodies, and, here, they felt like a team member who was valued and had control. They're encouraged to raise questions and to propose solutions.

At Group Health of Puget Sound, we found a successful medical home model that not only decreased use of emergency departments and the rate of ambulatory care-sensitive admission but also increased patient and staff satisfaction, with less burnout among the primary care physicians -- a notable step in an era when they may be in short supply.

At the same time, fee for service payment systems reward volume and do not differentiate on quality and therefore do not encourage high performance. For example, you may remember the case of Virginia Mason Medical Center, where the process for lower back pain was reengineered. They reduced use of MRIs and accelerated the use of physical therapy. Paul Ginsburg, who will be here tomorrow, documented the result, which was an increase in value for the employers who saw fewer days of work lost and lower costs for the decrease in revenue for Virginia Mason.

Commissioners have often expressed concern that doing the right thing is not rewarded in Medicare. In the long run, we'd like to encourage high-performance systems by changing the incentives in Medicare payments systems to better reward quality in care coordination.

In our workplan today, we hope to take a first step and investigate what high-performance systems are doing and how Medicare could recognize it. Then, later, we could consider the policy implication.

To identify high-performance systems that may be of interest, we're proposing to draw upon our site visits to the systems show on the slide and others we've undertaken. We'll look at case studies in the literature, including integrated systems and group practices of varying sizes. Also, we'll take your suggestions for candidate high-performance systems.

We talk about some of the sources for case studies in more detail in the mailing material. We hope to capitalize on the information in them, so we don't have to duplicate those efforts.

After identifying some systems, we then ask a few key questions. First, what are the systems doing to improve

performance? Care coordination holds promise for increasing longitudinal efficiency by decreasing unnecessary readmissions. At the University of Pennsylvania, we found that a pharmacist is now being called in to consult with the patient prior to discharge, to help eliminate potential drug interactions and to make sure the patient knows what drugs to take and when, when they get home.

Reengineering the process of care is an important step for many systems. For example, we have noted that a number of hospitals are standardizing their workflow with standard order sets and protocols. This is necessary to define a process sufficiently, so that if changes are later made to the process you can tell if there's been an improvement.

Another key question is: How are the systems measuring performance, what metrics are they using? Some measures are about internal efficiency. For example, at Virginia Mason, nurses work together to improve assignment of patients, so that nurses care for patients who are physically proximate. The nurses walk less and can respond faster. The hospital team actually measured how far nurses walk per day before and after the process was improved.

Medicare may not want to measure how many steps nurses take, but it may want to know the process has been improved and perhaps communicate that to other hospitals. Measures of more obvious interest to Medicare would be patient outcome, such as mortality and readmissions, or perhaps access to care. One measure may be how long do people have to wait for appointments.

Now MedPAC has measures that we've used to characterize efficient hospitals. We use the three shown here in our Analysis of Efficient Hospitals in the March report. We plan to see if the hospitals we identified are the same as those in the high-performing examples. We hope to learn from the comparison, what measures do and do not identify the same set and how we might improve our measures.

We would also investigate in systems with multiple hospitals whether or not all the hospitals were identified as efficient. This might tell us something about whether characteristics were strongly system-dependent or if they were more idiosyncratic to the individual hospital. This might give us a better idea of what works and what doesn't to improve performance and efficiency.

In summary, our study approach is to choose high-

performance systems identified in the literature or by you or by us. Then, identify what those systems are doing to improve performance such as process reengineering, care coordination and how they're measuring success. Next, we would compare those results to systems we would identify as efficient using our measures, and, from this comparison, we would hope to identify what kinds of innovations are consistently associated with effective and efficient provision of care and try to learn how Medicare might be able to recognize high performance.

We would then be in a position to better understand the implications for policy development. For example: How could promising innovation be disseminated to other providers? Should conditions of participation be rethought? How should ACOs be designed, and, eventually, how should payment policy be altered?

So, if this works out, we would aim for a chapter in the June report.

Now one further refinement we may want to consider is what perspective we take in this work. On the one hand, our natural focus would be on the Medicare perspective. Is the system's high performance for Medicare patients? We

might use Medicare claims to determine resource use and some quality metrics, and we could even use surveys of Medicare beneficiaries for other quality metrics.

On the other hand, we might want to consider the all-payer perspective as well. For example, a system might be efficient for Medicare, but Medicaid patients don't have access to it. Should this system's efficiency be thought of differently?

Also, other payers also have to accept high prices if a provider has market power in an area. We have found that hospitals not under financial pressure, because they can charge high prices, have higher costs than hospitals that are under greater financial pressure.

Because Medicare sets prices, the high provider costs would not be evident from Medicare's perspective. However, the high costs are of concern to Medicare. Medicare may not have to pay more immediately, but the perception that Medicare rates are not adequate can grow if providers' costs are not kept under control.

This is not an abstract concept. In a recent forum, an employer asked why. If the local system was so great and efficient, why was it he had to pay higher

premiums in that area than in other areas where he had stores?

High prices can coexist with seemingly efficient practices. So you may want us to take that into account as we consider efficiency.

So, for discussion, with these points in mind, we'd like you to talk about the following:

Would the study, as we described it, be valuable to you?

What should we change in the study approach?

Are there specific systems you'd like us to consider? The large integrated systems such as Kaiser, Geisinger, Intermountain are often mentioned, and also several of you have mentioned the Veterans Health Administration. The VHA may take a little more digging to get data for our purposes, but it could be considered if you think it worthwhile.

We could also look at smaller practices or individual hospitals. We're open to suggestions.

Finally, would the results be useful, going forward? Perhaps, there's a means to disseminate best practices to other Medicare providers or for setting future

policies, for example, around bundling or accountable care organizations.

We look forward to your discussion.

MR. HACKBARTH: Thanks, David.

Round one, clarifying questions.

DR. MILSTEIN: David, can you clarify in slide 3, are these the site visits we've already conducted or is this the proposed list?

MR. GLASS: These are some we've already made. We are open to doing some more. There's quite a few others we've also made, not specifically for this task but for others.

DR. STUART: I think it's self-evident that we need to understand what's out there and be able to identify high-performing systems. The chapter, as it's developing, seems a bit ad hoc, however, in terms of what your selection criteria were.

So my question is has there been a literature review here?

Glenn is On the Commonwealth Fund high-performing health system. What kind of communication is going on in terms of how these places are selected and then how that

information is going to be put together to develop the chapter?

MR. GLASS: We were thinking of taking their list as our starting point in some sense, the Commonwealth Fund. Now their list, as I understand it, originally, they did a kind of sum-data analysis, and then they had kind of an expert panel Delphi approach to identify which systems they thought were investigating. I think they initially came up with 15 and, since, have done quite a few more too.

So we're thinking of starting with that list, and then also, by using our measures of efficiency and that sort of thing, we were going to come up with another list and see where they intersect and where they didn't and perhaps look into both of those.

DR. CASTELLANOS: Good points. Two questions, these are real-world questions: One is what percentage of health care delivery systems or practices are integrated in the United States, and have you looked at any of the other systems that are not integrated?

DR. STENSLAND: It kind of depends on what you mean by integrated. But, if you go the strict kind of definition where there's common asset ownership of the

hospital and the physician practice, you're probably on the order of 30 percent or something in there. That's looking at the hospital as kind of the entity of what share the hospitals are formally integrated with at least some of their physicians.

And, if you want to know what share of the physicians are formally in one of these entities, it's going to be less than that.

DR. CASTELLANOS: Did you look at any of the non-integrated systems as high performance?

DR. STENSLAND: In some of these times, when we went to look at hospitals, when we started out looking at what we thought were efficient hospitals and looked at their system and how did they relate to the physicians in the greater system, there were some of them that weren't formally integrated and still performed well on our metrics.

I think as we go through and trace them over time, like at one time they looked good and some of them have kind of fallen off on their performance metrics.

I think one of the things we're going to have to look at is how do they, if they're not integrated, how do they get physician buy-in to coordinate care. That's

something that I think Arnie has talked about a lot is standardizing work, and on some of these site visits how do you get the doctors to come together and agree to standardize work, if they're not on salary, if they don't have a formal relationship with the hospital.

So I guess that's a long answer to a technical question, but there is definitely some work that we'll do, trying to look at both the integrated systems and unintegrated systems and look how those two types of organizations address some of these key issues, like standardizing work.

DR. CASTELLANOS: Thank you. That's exactly where I was going.

DR. BERENSON: Following up on Bruce's question, I know that Steve Shortell and Larry Casalino and colleagues have published over the years a series of papers where they have identified work process activities that they think are associated with high performance. Have you looked at that and does that lead you anywhere in terms of what you should be sort of looking for or to even specific places?

I believe they have a network that they go back to periodically, of practices of various kinds.

DR. STENSLAND: Yes, we've talked to Steve Shortell and Larry Casalino in the past about some of those issues, but we should probably revisit some of those sites that they brought up, and especially some of the sites that aren't formally integrated that I think Larry Casalino has highlighted.

DR. BERENSON: Do you have a sense that they've captured a number of sort of the work process activities that we should be looking at or are they too process-oriented and not focused enough? I guess you're focusing more on outcomes.

Do you have any sense of that or you haven't really looked at that point of view?

DR. STENSLAND: Just recalling what they presented to us and what we've seen from their work, I don't remember that kind of stuff in there, but I don't want to say that it's not there. They've done a lot of work that we probably haven't seen.

DR. CROSSON: Maybe I can speak to that. It's called the NSPO database, National Survey of Provider Organizations. They do have a broad set of information. It's self-reported information, for the most part, and they

update it every five years. I can't where in that five-year cycle that they are.

MR. GLASS: We can certainly look into it.

MR. HACKBARTH: Other clarifying questions?

DR. MARK MILLER: Can I just say one thing quickly then, and again it was just triggered by your comment. I think, explicitly, one thing that we're trying to say in looking at this is it's not just looking at care coordination activities, that we would explicitly try and look at what is typically referred to as the reengineering type of stuff because we haven't put tons of effort into that. That's an explicit thing. If people want us to do or not to do, you should feel free to comment on it.

MR. HACKBARTH: What actual data are available to assess overall efficiency other than the Medicare database?

So, if we were just taking a strict data-driven approach, I would think what you would do is look at the Medicare data and look not on a per admission basis but on a population basis, and that's how you would identify efficient providers. Not that that's the truth, but it's the only data, isn't it?

DR. MILSTEIN: On this point, Medstat has a

national commercial payer database that is not robust in every single community, but in many communities, and would allow these important crosswalks between is it both efficient for Medicare and efficient for commercial payers. The National Business Group on Health is pursuing a merger actually, through Dartmouth, of these two perspectives on cost efficiency.

MR. BERTKO: Yes, and I was going to add Medstat, and -- I think, Arnie, you would agree -- larger employers, you can use premiums at a local rating level for most metropolitan areas because they tend to be fairly specific down to even zip code level, and those might be available over time as well.

DR. BERENSON: If I could jump in, anticipating tomorrow's discussion and what David talked about a little bit, the need to distinguish the cost to the organization and the cost to the contracting, I mean to the purchaser. I mean it could well be that that difference is profit.

MR. BERTKO: [off microphone] Yes, but not entirely.

DR. BERENSON: I understand. But I mean it would be nice. I mean one of the things we may learn tomorrow is

that there may be efficient organizations but that purchasers don't benefit from that efficiency, although the previous work you've suggested on the hospital side is that they're less efficient if they have market power to get high prices. But I think it's important to distinguish cost to the organization and cost to the purchaser.

MR. BERTKO: Yes. Arnie's suggestion on Medstat, though, would generally have the cost of care claims and not the profit or admin piece.

DR. CHERNEW: But it doesn't have great outcome measures, some, but not.

MR. HACKBARTH: Okay, round two comments, let's start on this side.

MS. BEHROOZI: I guess I'm really interested to see the list of all these characteristics, but I would want to make sure that it's as broadly applicable or applicable to as many different types of providers as possible, so that there wouldn't be reasons for people to say, well, yes, they can do that because they've got whatever homogeneous affluent population that all lives within six blocks of the best providers or whatever.

So, can we make sure that we have a range of

socioeconomic status represented and diversity ethnically and whatever, and in various different ways if we could just make sure that the institutions that we're picking reflect a range of types of patient populations that they're dealing with?

Also, I guess this kind of goes back to Ron's clarifying question. The institutions that you identified when you were showing that high-cost hospitals tend to receive high payments from non-Medicare payers, you did identify institutions across the board, as I recall, small and large, teaching and non-teaching, high Medicaid share. I think you looked at that.

So are there institutions to look at there, regardless of their level of integration, but rather simply how are they doing it? How are they keeping their costs low for all payers?

And, as I recall, you also had a quality measure in there. How robust was it, I don't know, but that seems maybe like a good pool to start with or to go to.

MR. KUHN: Thank you. This is exciting stuff and thank you for doing this. I think it not only is a chance for us to impact future policy discussions but also,

hopefully, and maybe that's wishful thinking on my part, this can help accelerate some of the new designs out there. When people have this kind of information, maybe you can push the demos, the pilots even faster through the pipeline is what I would hope to do.

Just on the issue of maybe more sites to look at, I don't have any specific names for you now, but I'll get back to you on this. But I'd really like us, if we could also see if we could find a few rural sites to look at as well.

I'm really interested and want to be a little concerned about the scalability of some of the things that we look at. So I want to make sure there's portability across all kinds of settings across the country, both rural and urban. So I'd like to work with you on some identification on that.

Then the area I would suggest is a little bit outside of the hospitals themselves, and that is there are a lot of consulting firms out there, working with institutions to help them on workflow redesign. While I think we have to be careful with some of that, because is it truly workflow redesign that takes cost out of the system or is it just

shifting costs to another department within the hospital. We have to be very careful of that.

We have a point in time now where hospitals have implemented things, but I think some of these consultants are thinking three and five years down the road and putting out new metrics and new ways for doing the feature. So, to the extent that we could capture that kind of thinking in what we're doing, to kind of get a line of sight of what's out there more on the horizon, I think would be helpful as well.

MR. BUTLER: So the questions about data remind me of later we'll be talking about the difficulties in measuring performance. I have great expectations about pursuing this but realistic in linking it to very specific outcome measures.

Having said that, my one comment is to think about this through another lens as well, and that is not looking at high-performing institutions but activities we think make a difference across institutions and studying whether they really do or not. You can do this while you're looking at high performance.

For example, IT, we keep bringing up. If you were

able to pick out what you felt now were very high-end users, could you begin to look across those institutions and say how is the outcome different? Is it making a measurable impact and in what way?

Or, you could take medical homes and say, for those institutions that are embracing it, is it making a difference?

So we start getting data and, in fact, some of the things we think are important and are considering, not just going to a high-performance and fishing around and say, what makes a difference?

A third one might be the characteristic of the medical staff, which we haven't really addressed head-on, and that's kind of maybe a narrow way to state it. But how physicians are organized and how they're working with the hospital, does it make a difference?

We hear one day if you're only salaried. Well, we know that that's not nearly as important as some other things. So the characteristic on the continuum of how the physicians are organized or not, does it really make a difference?

I could go to vertical integration. If you, in

fact, have aggressively gone after vertical integration strategy, where you own and have most of the pieces, does it make a difference?

So whether we go after high-performing institutions as the fundamental unit of analysis, or some of these other areas, you're probably going to do both. I would just keep those in mind, so we're not just kind of searching for what works but have some framework about the things that we really want information on.

MS. HANSEN: Mine are brief because I just want to reiterate the idea of other systems that you'll be looking at, and it sounds like there will be some other suggestions of ways to look at it because the ability to diffuse will always be, of course, with the high-performing large systems, but there are other best practices with the outputs. I think, Arnie, you wrote a bit in Health Affairs on some of these smaller practices, but whether or not, how we still do the diffusion of them in the meantime.

On the second aspect -- it actually relates to Peter's last point -- I tracked to one particular set of variables that are more qualitative, and that is relative

not only to the physician leadership. But it's kind of unusual, the arrangement and the characteristics and conditions that make it possible for, say, the hospital administration and the physicians, and possibly I think in some systems I notice that even the chief nurses that have figured out a way to work together.

So it's again qualitative, more attributes, but what are the preconditions, and it has to do with one of the points in the last presentation. If we're going to have leadership in driving change for the future, it comes in a partnership, and Nancy would probably be the one to speak about that with physician management, leadership. But there's something here that I don't know oftentimes gets identified as how crucial leadership is in order to do that. As I say, it's more of a qualitative component, but I think it's one of those intangibles right now.

MR. BERTKO: A couple more additions to your thinking about this, like Herb, I think looking at a few rural places, but I also suggest some micropolitan areas. That is those smaller cities with a single hospital in town and those independent medical practices.

I forgot whether, David or Jeff, you mentioned

this, but looking at it on a multi-year horizon to see which ones have been successful for, say, all of three years. We might also learn something from those that looked three years ago and then failed, fell off the wagon, somewhere down the line.

Then, lastly, with everything that's going on in this and reform, looking at keeping some eye on the all-payer part, that is probably focusing on the Medicare end of it only because the data is easier to get to, and then on selected cases, going to Medstat or some other source of even hospital profit reports to see what's the change there. However you can, but to look at broader answers rather than just Medicare only.

DR. CROSSON: Just in terms of how you end up categorizing the systems, I think you know this, but obviously how the system is paid -- whether it's primarily or completely prepaid, or primarily or completely paid by fee for service -- is important to know.

In addition to that, then I think when we're looking at efficiency we're going to be potentially looking at both efficiency within a unit of service and also efficiency on the basis of population costs. I think those,

for obvious reasons, may also distinguish.

I can almost see a two-by-two table of sort of where does the organization that's prepaid go after unit costs, where does it go after population-based costs.

Then for the organization that's fee for service, does it go after unit-based costs in the same way? Maybe. And, does it have any plans necessarily or practices that would influence population-based efficiency?

MR. GLASS: An interesting subset is those that own, that have their own MA plan or health plan associated with them, and maybe we can gather a little more data from that perspective.

DR. CROSSON: Right. So those would be some of the ones who all are paid in part, prospectively. One of the questions there is how much prospective payment do you have to have before you start thinking seriously about population-based costs?

DR. BERENSON: The only additional thing I'd want to add is sort of this issue that comes up a lot is around culture and leadership in high-performing systems, and it's hard to tease all of that out. So I guess what I'd be interested in is going to some places that have not been

around for 50 years and to sort of get some sense of how do you start one these -- so, maybe a couple of organizations that have developed, what they've developed over a five-year period or something, and isn't Geisinger or Kaiser or Group Health of Puget Sound.

MR. HACKBARTH: [off microphone] [inaudible] make sure where we are relative to the overall time. Am I missing anybody else?

DR. KANE: Well, I feel kind of like I'm sitting on a doctoral research committee right now, kind of getting ready to caution the student about biting off way too much to chew here. I think just listening to all the variables, all the outcome measures, all the possible selection criteria, I'm going, whoa, good luck. I hope you have a real big budget and a long time frame, but I think this is awfully ambitious and our expectations are perhaps a little too high.

I have actually got a grant to look at -- I don't mind the competition. I welcome it. But I've been working on a project around high-performance safety net hospitals for the Commonwealth Fund. One of the things, for instance, we've found in looking at all the different ways you might

identify them is that they don't correlate that well. So somebody who has got high financial performance doesn't have high quality performance.

So it gets to be really not that easy to pull out, even what you mean. It took us a year, and we're still fixing this. It took us a year to just figure out what we think is a high-performing system and on what metric are we going to weight that definition.

So it's not that straightforward even to come with what do you mean by high-performing, not to mention all these different confounders you want people to account for. I mean I would throw in socioeconomic factors as well as a capitation revenue or percent, whether they're integrated or not, and owned or trying to deal with herding cats. So there's a lot of variables in there that I think make it pretty challenging.

A way to deal with that might be to look more specifically at some of the things that are related to the payment reforms that are probably going to happen. The big one I see that would be a really fascinating one to sort of start to tease out what are the differences that really matter to us is around the readmission piece because it does

say -- you know.

Look at the high and the low end of readmission and say, well, who is doing a good job of this, adjusting for case mix and even socioeconomic characteristics, I think, because I think that plays a role. Who is doing a really good job and maybe even in a place you wouldn't expect it, and then who's doing not such a great job in a place you would expect it, because a lot of that has to do with how well can they manage across the different delivery silos.

These are the things that Medicare is going to be really pushing, and we are going to be needing to give organizations guidance or advice or models of how do you manage that readmission rate.

I've had doctors come up to me in my classes and say: That's ridiculous, that I should care about a patient post-discharge. I'm done.

So, just that little thing, that little how you manage readmission rates and who has got low ones and high ones and adjust for the confoundings and then say, now who's really managing this in an effective way and why -- I think that would be really valuable 1-year exercise as opposed to

this 60-tome research project that we've all just produced for you.

Anyway, I love the idea. Having been doing it for a while, I can just say you really want to start a little bit more focused than trying to take on everything in as broad a definition as a high-performing health system, which could mean anything.

DR. MILSTEIN: I almost never disagree with Nancy, but on this occasion. I think we benefit, and always do, from a diversity of pristineness of the evidence base on which we and policymakers make decisions. So I endorse Nancy's perspective of a scientifically pristine identification of high performers, but I think there's a lot of usefulness and wisdom in making the best of what we have.

If we were happier with our status quo, then I would say let's wait for pristine evidence. But I think we have a lot of evidence our status quo is not very good and is not moving in the right direction. So, for that reason, I would advocate that I wouldn't pull back on the level of ambition that was outlined at the beginning.

I think, fortunately, we have Nancy and other methodologists around the table to help us understand just

how imperfect our evidence is. I think we ought to reach for the best available evidence on which delivery systems seem to be achieving a lot better clinical outcomes and burning a lot less, per person, per year, health insurance fuel across all payers.

I think it's going to be very difficult to do, but I think it's doable. With the databases we can access, I think we can come up with policy-useful conclusions.

DR. CHERNEW: So I think this is a perfect time in some ways, given the Nancy/Arnie discussion. You might figure out where I'm going to come down. The first thing I'll say is I have to tell you, honestly, I'm probably on the skeptical side of the ability to believe that you'll come back and tell me something that later I would want to put into some recommendation.

I'll make a few quick comments. The first one is you need to look at low-performing systems because I have not yet found a system that doesn't have some great things that they're doing, that I could go in and figure out, oh, they have a new system or this person is doing that. Right? So I think you really have to do a survey of low-performing ones because it's important to have a comparison group.

I think you have to supplement everything you do with data. Then after you find that they don't correspond, are you going to say that there's something wrong with the interview process or there's something wrong with the data you had or something wrong with the measures? That's going to be very hard to tell.

The one recommendation that might be more constructive that I would make is I think for MedPAC a statement that more funding for AHRQ and more money to go to these types of endeavors to be done in sort of broad, rigorous ways, I think is a useful activity. But I'm not yet convinced that going to places identified as high-performing and letting them tell you all the wonderful things they are doing tells us anything about how generalizable that would be or how we should change policy.

DR. CASTELLANOS: Jeff, I appreciate your comments, and you and I have talked about this in the past. I guess carrying on what Bob said is what can we learn from this, and what I'm interested in is how can we diffuse this information out. Not just learn about it, but how can we diffuse it?

I can tell you most communities are not

integrated, most hospitals are not integrated, and most physician practices, offices are certainly not integrated.

DR. BORMAN: Recognizing all the challenges, I still think that at least a run at this would be helpful just because I think we previously have seen best attempts to categorize efficiency, and you set some high and low criteria for us before, about hospitals. So we've made a good run on at least that database. Let's make a run on the qualitative side.

Let's not turn it into the science project of the century, but I think it would be informative to make a run at the qualitative side. So I do think that there is some value to this.

I think that one of the questions that you posed, that perhaps some selection would help you answer is: Is it a hospital factor or a systemwide factor? I have a couple of examples I'll be happy to share with you that I think might help you get to that.

I agree about the rural piece. I have at least one I can think of that I'll share with you, about getting to that.

I think this could be an opportunity, to the

extent that places you identify sponsor graduate medical education, let's see if we can tease out while we're there, a twofer. Do they have anything that they can comment, give us feedback about, how the things that they've done to become high performance or whatever have in fact impacted their -- and I'll give you an anecdotal example that I'm aware of, just to think about.

Then I think another question would be could you look at, would you want to look at for your list -- you know we've had the list of people who participated in some of the PGP projects. Is that a list to start from?

Also, your objective analysis previously of hospitals, you had some real outliers at the high and low ends. I would agree with Mike, a little low end investigation could be helpful. Getting a couple of these lists together and pick the ones that keep popping up might be the biggest bang for the buck.

The other thing would be whether any of these, whether the sites, if there's any site within the areas that are doing the physician research utilization reports could qualify for your work because that might help give you an example, particularly for the less integrated groups, of

that physician medical staff or some of those practitioners, how that relates. That could be informative. Perhaps one tiny way to start coming at the less integrated issue would be maybe some thoughts about where to go with it.

DR. DEAN: I think probably my thoughts have already been stated. I just wanted to follow up, especially on what Jennie and Bob said. I think as we look at this, first of all -- and I think it's an important direction to go -- we need to try and tease out the success of these facilities or organizations, how much of it is a result of either structural or policy issues as opposed to unique local issues.

My suspicion is an awful lot of it is due to local issues and especially local leadership, but I think we need to try to distinguish if there are things that policy changes might affect, unless we can figure out a policy approach that will generate leaders.

MR. HACKBARTH: I'm not a researcher, so all my comments should be taken with a grain of salt. But, as an utter layman on this sort of thing, it does seem to me that maybe the greatest opportunity to learn is from the organizations, as Bob says, that are recently changing. The

ones that have 10 and 20 and 50-year histories, they're important, but in a lot of ways they're also unique.

So it seems to me from our perspective, a policy perspective, the really interesting cases are the ones who have initiated change recently in a move from low performance or mediocre performance into a higher performance category and what allowed them to do that and, in particular, since this is the Medicare Payment Advisory Commission, to what extent is how they're paid an important influence in their ability to accomplish rapid improvement.

I can imagine there are all sorts of different cells in this research, but, boy, that's the one that seems like it would be really interesting to me.

DR. CHERNEW: You still need to know why the ones that had the same payment system didn't make that evolution. It's the differential, because you'll always be able to go in and craft some great ex post story, and then you'll think, oh, if everyone could just have done this.

Often, you end up, it's just [inaudible]. That's why they're so good. But she'll tell you a whole bunch of things that aren't that. So you need some comparison.

MR. HACKBARTH: We are at the limit of our time on

this. I hope we helped a little bit.

MR. HACKBARTH: Now we will have our public comment period before we break for lunch, and Karen well knows our ground rules, but I will repeat them anyhow. No more than two minutes and please, Karen, begin by identifying yourself and your organization. When the light comes back on, two minutes is up.

MS. FISHER: Terrific. I'm Karen Fisher at the AAMC, and if I have more to say, maybe I will use that new nifty comment site on the MedPAC website.

First of all, thank you, as always, talking on an issue that we view as important at the AAMC. We are very interested in looking at delivery reform and payment reform, and it was alluded to, the issue of health care innovation zones, which has been developed by the AAMC to help test out some of these ideas, and I think with an emphasis on test because no one is exactly sure what we mean.

I also thought slide 13 was interesting. I wish, though, that it went beyond Medicare because it was mentioned -- but I think it is worth emphasizing -- that for the Medicare direct GME payment, it is only paying Medicare's share of a total cost value. So hospitals, the

teaching hospitals who enter this area, have to find other resources to fill up the rest of the costs. And I wish that you had a chart to talk about that.

That is also true on the IME side. The Medicare IME payment is an add-on to Medicare cases. And to the extent that teaching hospitals have higher costs for other payers -- Medicaid, uninsured, and private payers -- they have to find additional resources for those costs. And while they may be out there, it is a risky proposition. It is not a guarantee, and it is in part the reason why teaching hospitals tend to have lower operating and total margins than other community hospitals.

With that being said, we would urge the Commission to reconsider the consensus or the possible consensus of not looking at all payer funding because we think that is important.

And, finally, we would urge you to reconsider looking at the issue of Medicare caps. They have been in place. It has been an artificial freeze since 1997, without any thought given since then except to redistributing those caps, but really to look at the issue of physician shortages and the roles those caps play in inhibiting the progress in

growth in physicians beyond we know that some people have gone over the cap for a multitude of reasons.

Thank you.

MR. HACKBARTH: Okay, we will break for lunch and reconvene at 1:30.

[Whereupon, at 12:24 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION [1:36 p.m.]

MR. HACKBARTH: Okay, it's time to begin our afternoon session. The first session is on the MIPPA mandated report on comparing quality in Medicare Advantage and fee-for-service. As I mentioned at the outset, we will be discussing draft recommendations today, and exactly when we have the final votes -- the normal course of events, if things go well today, we would probably do it next month, Mark? Okay. So who is leading the way? John?

MR. RICHARDSON: Good afternoon. Carlos and I are here again to discuss the Congressionally mandated report on how to improve comparisons of the quality of care among Medicare Advantage plans and between MA and fee-for-service Medicare.

Section 168 of the Medicare Improvements for Patients and Providers Act of 2008 requires the Commission to study and submit a report to the Congress on how performance and patient experience measures can be collected and reported by 2011 to allow comparisons of the quality of care between Medicare Advantage and fee-for-service Medicare and among MA plans. The statute directs the Commission to address technical issues such as the implications of new

data requirements and benchmarking of performance measures. The report is to include any recommendations for legislative or administrative changes that the Commission finds appropriate.

The meeting materials we prepared for this session and our presentation this afternoon are the synthesis of our study that's included input from you at two previous Commission meetings, discussions with a diverse group of stakeholders, and an extensive literature review. Today, we will present a series of policy options in the form of draft recommendations for your consideration.

However, before we get to the draft recommendations, we think it is important to step back and highlight two key considerations that have framed our work on this study and the development of the draft recommendations.

First, as summarized on this slide, we were cognizant of at least three different purposes and audiences served by information about quality of care. Each group shown here, Medicare beneficiaries, CMS program managers, as well as agency and Congressional policy makers, and providers and plans, use this quality information for

different ends, and therefore they have divergent needs for the types of information about quality and the formats in which they can absorb and use the information.

For example, beneficiaries who want to compare the quality of MA plans that they are thinking about joining need information about how the plans performed in their local area, not at a Statewide or national level, and they may be most interested in the overall outcomes of care and beneficiaries' experiences of care in the various plans they have to choose from. CMS and providers will have their own priorities for quality comparisons. Ideally, the quality measurement and comparison approaches that Medicare uses should be flexible enough to accommodate these various audiences' different information needs.

We also have been guided by the Commission's past recommendations on aspects of comparing quality between MA and fee-for-service Medicare and within MA. In March 2005, the Commission recommended that CMS should collect certain laboratory test values in fee-for-service and thereby obtain information such as cholesterol and blood glucose levels that are used for so-called intermediate outcome measures. In June 2005, the Commission recommended that the Secretary

should calculate quality measures in fee-for-service that could be compared to results from MA.

Within MA, the Commission has recommended that payments to MA plans should vary based on plans' relative performance on quality measures. In March 2004, the Commission recommended setting up a pay-for-performance pool financed by a small portion of plan payments that would be redistributed to high-performing plans and to plans that showed improvement over previous years' results.

Then in June 2005, while recommending that MA benchmarks be set at 100 percent of fee-for-service, the Commission also recommended that funds that would otherwise have been retained by the Treasury when plan bids were below these benchmarks should be given back to plans in the form of quality bonuses.

And lastly, while not a formal recommendation, the Commission in its June 2009 report to the Congress suggested that higher quality plans should have higher payments than other plans during the transition to plan payment benchmark levels that are based on local fee-for-service payment levels. The Commission also discussed paying MA plans more than fee-for-service when they had demonstrably higher

quality than fee-for-service.

Now, we will turn to the draft recommendations. At the start of our journey, we thought it would be helpful to give you a roadmap to the territory we will cover. The table on this slide is organized around four cross-cutting issues and three types of quality measures that are addressed by the draft recommendations.

First up is the issue of the appropriate geographic unit for reporting and benchmarking quality measures. Here, the draft recommendation is that the geographic unit should be the same in both MA and fee-for-service. In most cases, this would mean that quality comparisons between MA and fee-for-service and among MA plans would be done at the local health care market level.

Going to the next row on the table, we will discuss whether the data collection and reporting that underlies certain quality measures should be made consistent across all types of MA plans, that is, HMOs, PPOs, and private fee-for-service plans, which currently is not the case.

Next, we will consider how the Health Care Effectiveness Data and Information Set, or HEDIS measures,

could be used to compare quality between MA and fee-for-service Medicare. Several existing HEDIS measures that rely on administrative data only may feasibly be used to compare some aspects of quality in both sectors of the program. Because some other HEDIS measures require laboratory information, we will look at enhancing fee-for-service claims data to include laboratory test results. We also discuss how new HEDIS measures would need to be developed to cover more segments of the Medicare population, such as beneficiaries over age 75 and under age 65, and underrepresented clinical conditions, such as mental illness.

Then moving to the fourth row, we will look at two surveys, the Consumer Assessment of Health Care Providers and Systems, or CAHPS, and the Health Outcomes Survey, or HOS, that Medicare currently uses to get the beneficiary perspective on quality. We will discuss how the sample size of these surveys could be expanded to allow comparisons below the State level and how a fee-for-service version of the HOS would allow comparisons of beneficiaries' health status changes in both MA and fee-for-service.

Next, we will discuss how Medicare could use a

starter set of outcome measures to assess and compare the quality of ambulatory and inpatient care in a local fee-for-service area or MA plan. These are all outcome measures that may be calculated using administrative data, such as fee-for-service claims or health plan encounter data. In 2011, MA plans will begin submitting encounter data to CMS, and if it is complete and contains the necessary data elements, these data could be the basis for computing the outcome measures on a comparable footing between MA and fee-for-service and among MA plans, including as much risk adjustment as is possible with administrative data.

At the second-to-the-last stop, we will consider the option of leveraging a timely opportunity that has presented itself this year in the form of CMS's efforts that are underway right now to define the criteria for the meaningful use of electronic health records, or EHRs. The meaningful use criteria are a central element in forthcoming Medicare payment incentives for EHR adoption, and defining them now to support collection of the data needed for more robust quality measures and improved risk adjustment could be invaluable to future quality comparisons.

And last but not least, we will consider the

potential budget implications for CMS of all the draft recommendations and whether the Congress should dedicate funding for the implementation of these activities to ensure that any quality comparisons between MA and fee-for-service Medicare and among MA plans are executed with sufficient resources to be as accurate as possible.

There also is a chronological aspect to the Congressional mandate that drives us to lay out the road map as we have. The MIPPA language calls for reporting on improved quality measures to occur by 2011. We therefore will discuss draft recommendations for changes that can be implemented by 2011, while other ways we might improve quality measurement are not feasible until after that date.

For the near term, by 2011, our draft recommendations include modifying and adapting the current MA quality measurement systems to improve quality comparisons within MA and to start comparing at least some aspects of quality between MA and fee-for-service, such as certain process and patient experience measures.

Other draft recommendations we will present, such as developing new quality measures to address gaps in the current systems and tapping into new data sources, such as

lab values, health plan encounter data, and electronic health records, would be longer-term prospects that are feasible beyond 2011.

Carlos now will start walking you through the draft recommendations.

MR. ZARABOZO: Our first draft recommendation will deal with the question of the geographic unit for the reporting of quality measures in MA and fee-for-service. As we have discussed in past public meetings, many MA plans report a single set of quality measures for a very wide geographic area, such as plans in California that cover much of the State, even though different parts of California have very different health care markets and the provider characteristics in each geographic area can be very different in both fee-for-service and MA.

Particularly for the purpose of informing beneficiaries about the relative performance of MA plans and the performance of MA plans as compared to fee-for-service, quality comparisons should pertain to a specific geographic area in which beneficiaries are making choices among different options. This will enable beneficiaries to know which plans are better than others and how fee-for-service

compares to available MA plans.

For CMS in its role as the entity monitoring the performance of plans and seeking improvements in plan quality, it is also important to evaluate the care that each plan provides in the different geographic areas in which a Medicare Advantage organization operates.

This leads to our first draft recommendation, which calls for the Secretary to collect and report data at a smaller geographic level than the current MA contract level. The geographic areas would be health care market areas or the reconfigured payment areas the Commission recommended for MA in the June 2009 report to the Congress. The same newly reconfigured geographic areas should be used for calculating and reporting fee-for-service results.

The draft recommendation reads, the Secretary should collect, calculate, and report performance measurement results in MA at the level of the appropriate geographic unit and calculate fee-for-service performance results for purposes of comparing MA and fee-for-service using the same geographic area definitions.

As we go along discussing the changes that are necessary for comparative reporting, you will see that a

number of issues are subsumed within this recommendation. For example, if today a particular MA plan's quality information is based on a survey of beneficiaries that gives you statistically valid results at the Statewide level, when you go to smaller market areas, you would have to increase the sample size to yield valid results in the smaller area.

As we have mentioned in the past, there is also a small numbers issue and that going to smaller geographic areas, you're dealing with fewer enrollees and sometimes too few to yield valid results. The Secretary would have to develop alternative ways of evaluating and reporting on quality in such cases, for example, by using a three-year rolling average.

The implications of this recommendation are that CMS would require significant additional resources to collect the necessary information and report it for each of the smaller geographic areas. The kind of systemwide reporting contemplated in the draft recommendation is not currently done in the fee-for-service sector.

For beneficiaries, the change would allow better comparability of quality measures. However, the response burden for beneficiaries in responding to surveys does

increase.

Many plans would face additional burdens and costs because of the increased number of reporting units.

As John mentioned, we are proposing to build on current systems as the basis for improved comparative reporting in the near term. The MA program has three systems that provide information about the plans' performance on quality measures. Two of those systems, CAHPS and the Health Outcomes Survey, obtain their information through patient surveys. The CAHPS-MA survey collects information about enrollees' perceptions of care rendered by plan providers, their ease of access to care, and the rating of their care and of their health plan. CAHPS is also the vehicle used for collecting information about vaccine rates among MA enrollees and information on smoking cessation counseling.

For the Health Outcomes Survey, enrollees are surveyed initially to obtain baseline information about their health status and then resurveyed two years later to evaluate their changes in physical and mental health. Some of the HOS questions also pertain to care that beneficiaries received through their health plans, for example, whether

beneficiaries that have suffered a fall receive fall risk management.

Those particular HOS questions on the care that enrollees received through their plans and the CAHPS questions on vaccines and smoking cessation advice are incorporated into the other performance measurement system for MA, which is the Health Care Effectiveness Data and Information Set, or HEDIS. HEDIS is primarily a set of process measures that health plans report, along with some so-called intermediate outcome measures. Examples include process measures such as screening rates for breast cancer, colorectal cancer, and glaucoma, and the intermediate outcome measures, such as the measures showing the extent to which diabetics are controlling their blood pressure, glucose levels, and cholesterol.

Now, I would like to talk about how the current MA systems can be used to compare MA to fee-for-service, starting with the patient survey instruments. In the case of CAHPS, there is an equivalent of the MA-CAHPS survey that is collected in fee-for-service. CMS already uses the CAHPS fee-for-service survey for comparing MA with fee-for-service on vaccination rates, for example.

Consistent with the first draft recommendation regarding the appropriate geographic unit, the only change necessary to CAHPS would be to expand the survey to ensure that each geographic area has a sufficient sample size to ensure valid results.

In the case of the Health Outcomes Survey, there is no equivalent survey in fee-for-service. Although such a survey could be instituted in fee-for-service, results of two years' surveying and resurveying of beneficiaries would not be possible by 2011.

Because fee-for-service lacks the equivalent of the Health Outcomes Survey, draft recommendation two directs the Secretary to collect and report on survey-based patient experiences and outcomes in fee-for-service in the same manner as is done in MA.

The draft recommendation reads, the Secretary should, for fee-for-service collect and report the same survey-based data that are collected in MA through the Health Outcomes Survey and ensure that meaningful distinctions among plans and across sectors are discernible in reporting results of the survey.

The second part of this recommendation addresses a

concern with regard to the Health Outcomes Survey, which is that the current reporting practices do not show distinctions among plans that could be meaningful to beneficiaries in choosing among plans. The vast majority of plans are reported as having outcomes that are within the expected range for their MA enrollees.

As for the implications of this draft recommendation, introducing the equivalent of the HOS in fee-for-service would require CMS to invest a substantial level of resources in the effort, but it would improve the kind of comparative information that beneficiaries would find useful. However, the response burden for beneficiaries in responding to surveys does increase. Plans would face additional costs due to the geographic unit recommendation that would require an increase in the number of enrollees surveyed.

Turning now to the clinical quality measures collected through HEDIS, what is possible in 2011 is to have CMS compute HEDIS administrative measures in fee-for-service. These are the HEDIS measures that are based solely on plans' administrative data, such as claims and encounter data. This includes measures such as the rate of breast

cancer screening, glaucoma screening, and monitoring of medications.

As we discussed in your mailing material, when MA plans report on HEDIS administrative measures, the sources of information from which they compute their performance include more sources than existing fee-for-service Medicare. In fee-for-service Medicare currently, the source for HEDIS administrative measures would be fee-for-service claims and pharmacy data. In health plans, lab values and electronic health records can be the source of information for computing HEDIS performance results. So even the administrative data cannot be perfectly matched between fee-for-service and Medicare Advantage.

Some of the HEDIS measures rely on more than just administrative data. Many measures, including the intermediate outcome measures, can be based on medical record information. For some health plans, the information is contained in electronic health records, but often the information is obtained by using a sample of medical records to determine the plan's rate for a given HEDIS measure. However, only HMOs can use medical records as a basis for reporting. PPOs cannot, for example. We will return to

this issue of a non-level playing field among MA plan types later in presenting one of the draft recommendations.

On the fee-for-service side, with respect to measures that rely on medical record review, CMS does not have access to medical records for fee-for-service, though there have been projects and studies that have evaluated quality in fee-for-service by reviewing samples of medical records to determine the performance of fee-for-service providers on HEDIS-like measures.

Given the time frame specified in the mandate and what is feasible with regard to HEDIS, our draft recommendation is that the Secretary should calculate HEDIS administrative-only measures for fee-for-service. This is possible by 2011. What is also possible by 2011 is to obtain lab values that would allow the computation of additional HEDIS measures in fee-for-service if the Secretary required the submission of lab value information in fee-for-service.

The draft recommendation reads, the Secretary should calculate fee-for-service results for HEDIS administrative measures by 2011 and begin collecting lab values in fee-for-service by 2011 and use the information to

calculate intermediate outcome measures for fee-for-service as soon as practicable.

Note that these draft recommendations are similar to the Commission's two past recommendations on data collection reporting, but they differ in that we are stating a specific date by which the Secretary should make the recommended changes.

As for implications of this recommendation, CMS would require a substantial level of resources to report HEDIS measures on a market-by-market basis in fee-for-service, but it would improve beneficiaries' ability to make comparisons. Entities that would be newly required to report lab results would face additional costs and burden.

In the HEDIS discussion, I mentioned that only HMOs are allowed to use medical record review as a basis for reporting certain HEDIS measures. In this draft recommendation, we suggest that all health plan types, HMOs, PPOs, and private fee-for-service plans, should be on the same footing and that all types of plans should report on measures that are based on extraction of information from medical records. In order for the Secretary to fully implement the recommendations, the statute would need to be

changed to eliminate an exception to medical record-based reporting for some plan types.

Therefore, draft recommendation four, which pertains only to the MA-to-MA comparison, states, the Secretary should have all health plan types, HMOs, PPOs, and private fee-for-service plans, report measures based on medical record review, and the Congress should remove the statutory exceptions for PPOs and private fee-for-service plans with respect to such reporting.

The implications of this recommendation are the CMS will require a modest level of additional resources to collect the necessary information and report it for each of the smaller geographic areas. For beneficiaries, this will allow better comparability of quality measures, but many plans would face additional burdens and costs because of the need for labor-intensive medical chart review among plans that do not have advanced electronic health records.

John will now discuss ways in which to improve quality reporting for each sector, MA and fee-for-service, from a near-term and longer-term perspective.

MR. RICHARDSON: An issue of concern we have discussed in prior meetings is whether the current HEDIS

measures are sufficiently comprehensive to adequately measure quality of care for Medicare beneficiaries. Among the HEDIS measures currently in use for MA plans, few non-drug-related measures apply to the oldest Medicare beneficiaries.

For example, of the six intermediate outcome measures, only one applies to beneficiaries between 75 and 85 years of age, and none applies to people over 85. All nine of the HEDIS diabetes care quality measures are reported only through age 75. While there may be sound technical reasons for imposing age limits in the diabetes quality measures specifications, for example, the fact remains that the specifications exclude a significant portion of beneficiaries with diabetes from the quality measurement.

Also, measures for the care of certain conditions, such as mental health care, exist in HEDIS, but are reported for such small numbers of beneficiaries that they essentially cannot be reported in their current form. There also are gaps in measures for certain types of providers, such as those serving rural areas. There also are few HEDIS measures that could show the effects of health plans' value-

added activities, such as outcome measures, like admission rates for ambulatory care sensitive conditions, and the rates of potentially preventable emergency department visits. That could show whether a plan's providers deliver care coordination services, such as care transition management and medication reconciliation post-hospital discharge.

Last, some of the quality measures currently used in fee-for-service, such as outcome measures, like readmissions and mortality rates that are used in Hospital Compare and perhaps certain process measures from the Physician Quality Reporting Initiative, could be used to expand the breadth of quality measurement in MA and in quality comparisons between MA and fee-for-service.

We have also discussed another large gap in Medicare's current quality measures by looking at four types of patient outcome measures, which are shown at the top of this slide. All of these measures can be calculated using available claims data in fee-for-service Medicare. They also could be computed for MA plans using the encounter data that CMS will require MA plans to report in 2011 if the specifications for those data submissions include the

elements needed to compute the measures. Outcome measures could be very useful indicators of the value-added functions of MA plans, such as helping plan members manage their chronic conditions.

Risk adjustment is also a very important factor in evaluating how to use outcome measures like these because the results can be affected by factors outside the control of providers and plans, such as patient behaviors, socio-economic conditions, and overall case mix and disease prevalence in the area or the plan being measured.

I will return to this point later, but for now, simply take note of the fact that EHRs could be an invaluable source of the data in the future that could be used to refine risk adjustment for outcome measures in both MA and fee-for-service Medicare. In the meantime, we have concluded that the four types of measures shown here would be an informative set of outcome measures that can be calculated and risk adjusted to a certain extent using fee-for-service claims data and MA encounter plan data.

This discussion of gaps in the current quality measurement system leads us to our fifth draft recommendation, which reads, the Secretary should develop

and report on additional quality measures for MA plan and MA-to-fee-for-service comparisons that address gaps in the current quality measures. In developing these additional measures, we would anticipate that the Secretary would assess the feasibility of using or adapting existing measures, including those used in fee-for-service Medicare, measures used in Medicaid managed care and fee-for-service programs for adults with disabilities, and measures developed by health services research organizations, such as the Assessing Care of Vulnerable Elderly, or ACOVE, measures developed by researchers at RAND.

Implications of draft recommendation five are that there would be increased CMS costs to develop and implement these two measures, but beneficiaries would have more pertinent quality information available to them based on specified characteristics, such as disease or race or ethnicity, and that there would be increased provider costs for collecting and reporting data needed for these new measures.

As I noted a couple of minutes ago, there are four different types of patient outcome measures that could be calculated using claims or encounter data. Draft

recommendation six pertains to the encounter data submissions that CMS already will require MA plans to submit starting in 2011, and this draft recommendation reads, the Secretary should publish specifications for the forthcoming MA plan encounter data submissions to obtain the data needed to calculate patient outcome measures.

Just as a reminder, we had in mind here the following four types of outcome measures: Potentially preventable admissions for ambulatory care sensitive conditions, readmissions for selected conditions, potentially preventable emergency department visits, and mortality rates for selected conditions.

The implications of this draft recommendation are that there would be no additional CMS costs above the baseline costs already assumed to specify and collect encounter data from MA plans, that there would be more information available to beneficiaries on patient outcomes when comparing MA plans and when comparing between MA and fee-for-service. However, providers and plans could incur costs above the baseline costs that are already assumed for the plan encounter data collection and reporting.

We are almost done. The next draft recommendation

concerns the meaningful use criteria with respect to electronic health records that will qualify for Medicare payment incentives that were authorized under the Economic Stimulus Law enacted earlier this year. The EHR meaningful use criteria will be defined by CMS through regulations that are expected to be issued by December of this year.

Draft recommendation seven reads, the Secretary should define EHR meaningful use criteria such that all qualifying EHRs can collect and report the data, including demographic data, needed to compute a comprehensive set of process and outcome measures consistent with these recommendations.

This recommendation would provide input to CMS to shape the definition of meaningful use to support the types of quality measurement that are considered in the other draft recommendations. For example, the Commission could recommend that all qualifying EHRs have the capability to report laboratory test values for the HEDIS intermediate outcome measures and the capability to report demographic and clinical data needed to calculate and risk adjust outcome measures. We expect that the breadth of quality measures, and therefore the definition of meaningful use of

EHRs, will also evolve over time.

The implications of this draft recommendation are that there would be no additional costs for CMS beyond the baseline costs that exist already for implementing the EHR meaningful use criteria. However, there would be much more information available to beneficiaries on a full scope of quality measures with reporting by face, ethnicity, gender, and age group, just to name a few demographic characteristics. There also would be no provider costs beyond baseline spending to acquire and use EHR systems that meet CMS's meaningful use criteria.

And last, draft recommendation eight. This draft recommendation relates to the importance of making sure that there would be sufficient funding for the Department to implement the Commission's other recommendations. Draft recommendation eight reads, the Congress should provide the Secretary with sufficient resources to implement the Commission's recommendations in this report.

The draft text shown in italics on this slide would explain the reasoning behind the draft recommendation, and we felt it important enough to have on the same slide. The reasoning is that the resources required to implement

the recommendations in this report are likely to be substantial. It is important to beneficiaries, providers, and policy makers that quality between MA and fee-for-service Medicare and among MA plans be accurately compared and the unintended consequences of inaccurate quality comparisons, which I should point out would be the likely result of inadequate funding, would be costly and detrimental. Because of this, we believe dedicated resources are necessary. The Secretary should submit a budget proposal to the Congress that specifies an estimate of the level of funding needed to implement the recommendations in this report.

The implications of draft recommendation eight are increased costs to taxpayers, beneficiaries, or plans, depending on the funding approach chosen by the Congress, and there also could be potential additional costs to beneficiaries or plans, again, depending on the funding approach chosen by the Congress.

That concludes our marathon here. In the event it is helpful, put back up the roadmap table and we look forward to your questions and discussion.

MR. HACKBARTH: Okay. Here is the approach I

would like to follow. We will do the round one clarifying questions, and then when we go to round two, what I would like people to do is specifically address the recommendations and identify which you can support and which are more problematic for you and why so we can give Carlos and John very specific feedback so we can wrap up this report. So let me see hands for round one clarifying questions.

MR. BERTKO: The first question is on the mortality reports out there. Are you thinking of hospital-based mortality only? Hospital plus 30 days after discharge? Hospital plus 90 days after discharge? And if the latter two, where would the mortality report come from, since I am at least unaware of health plans, for example, being aware of when people actually die.

MR. RICHARDSON: We were thinking about 30-day post-discharge to maintain reasonable consistency with what CMS already does for Hospital Compare. All of those measures would be calculable -- in the case of MA plans, you would need to get encounter data or EHR data eventually that would do that. In the case of the calculations based on encounter data, CMS would have to do that, which is why we

were talking about the resource needs for them, and presumably they would do what they do with the fee-for-service, where they would use the enrollment database or the Social Security death records to confirm what the date of death was, and then calculate --

MR. BERTKO: Okay. So CMS would do all that. That is --

MR. RICHARDSON: Yes. Obviously, the encounter data piece would be from the plans, but CMS would be doing the calculations, which is why that resource piece is in there.

MR. BERTKO: And then the second question on clarity is, is your statement on the collection of lab, clinical results data, implicitly saying that clinical data would be added to a billing form in order to allow the bill to be paid, so that would become the collection mechanism?

MR. RICHARDSON: One could do it that way. One could also, to the extent that there's another database that would have laboratory test values in it, somehow merge those. But I think that the claim-based approach is the one that we were thinking of.

MR. BERTKO: Yes. I'm thinking that Statewide

reference labs are quite good, but they have only -- at least when I was at a health plan, only 50 percent of the data collected in lab results from doctors' offices, and to some extent hospitals, it is not collected anywhere unless you have an EMR, and those are not always prevalent.

MS. HANSEN: Two short clarifying questions. On draft recommendation number four on page 17, the last comment of including PPOs and private fee-for-service, this would be probably the first attempt at bringing everybody under the tent in order to have similar reporting requirements?

MR. ZARABOZO: Well, no. All plans will be reporting, you know, beginning 2011. But this is sort of a narrow issue that in the statute, it says, for example, PPOs only have to report on the performance of their network providers. Now, it looks like in reality they are reporting for all providers, at least based on discussions with CMS, but there is that statutory provision that limits who they have to report on. There is also another provision that came from MIPPA that said that for the medical record-based measures, that the private fee-for-service plans did not have to do those. It is a little bit complicated wording,

but that is the gist of it.

MS. HANSEN: But it brings them back in --

MR. ZARABOZO: Right. This is intended to bring everybody on the same level.

MS. HANSEN: Great. And then back to page 14, in terms of what is reported, you have pharmacy data there, and I know it's very difficult to gather if you don't have an EMR system, but that would not be -- or how does that relate to a previous discussion of bringing in Part D data and --

MR. ZARABOZO: This assumes that we have Part D data.

MS. HANSEN: Okay.

MR. ZARABOZO: This says this is currently available on both sides, essentially.

MS. HANSEN: All right. Thank you.

MR. HACKBARTH: Could I just follow up and ask my clarifying question? It has to do with 17. I'm sure I'm missing something obvious here. So we're saying now we're going to create a level playing field, as it were, among the different types of MA plans and say they all have to have medical record-based measures. What about fee-for-service Medicare?

MR. ZARABOZO: Well, that is the point that we made, that CMS doesn't have access to medical records currently --

MR. HACKBARTH: Right.

MR. ZARABOZO: -- so this is -- what we lay out is you can do administrative measures right now comparing -- HEDIS administrative measures, you can do fee-for-service to MA. The medical record thing, this recommendation pertains to the MA-to-MA comparison. We want everybody within MA to be on the same footing. But there is a gap in terms of you cannot compare --

MR. HACKBARTH: What I am getting at is wasn't the argument that the private fee-for-service plans made that they don't have contract relationships, therefore, they don't have the means, just like fee-for-service Medicare, to get access to medical records?

MR. ZARABOZO: Right, and it's the same issue with the PPOs. This would require them to go into offices where they do not have a contractual relationship.

MR. HACKBARTH: Was it on this particular issue, Herb?

MR. KUHN: I'm just curious, Carlos. Is there a

way, though, on the fee-for-service side for Medicare to create a series of G-codes so that they don't have medical records extraction on the fee-for-service side, but could they create a set of G-codes that could substitute for this in the interim?

MR. ZARABOZO: Yes, similar to --

MR. KUHN: So it could be done.

MR. ZARABOZO: Yes.

MR. KUHN: It could be done. I mean, it's not as precise and it's a little bit of a burden on the reporting side, but it could be done through a G-code set.

MR. ZARABOZO: Right, but the --

MR. KUHN: With their own code descriptors on those, et cetera, right?

MR. ZARABOZO: You would weigh that against, though, the outcome -- you know, if there are other measures that can't be calculated from the claims --

MR. KUHN: Right.

MR. ZARABOZO: -- what are you looking for in the way of measures and do you have enough information based on which you can calculate claims and encounter data to not make that necessary.

MR. KUHN: Right. But for some measures, the potential is there, though.

MR. ZARABOZO: Yes.

MR. KUHN: Okay.

MR. BUTLER: Okay. I'll ask a little bit of an unfair question, but I'm hung up a little bit more on the cost side of putting all this in place, because every recommendation says CMS more, CMS more, and, in fact, then you say, or we might say the Secretary should come back with a budget for us. There's also cost references on the beneficiary plan and provider side of things.

So we're into CBO scoring these days, I guess, but I'm trying to get some sense of what we're talking about in terms of either a budget for a CMS side or on the provider and plan side, you know, wake me up when we've got electronic health records. Most of the costs will go away. So just talk a little bit more, if you could, about what we would -- the backlash we would be getting if we go forward with this in terms of people's cost burden.

MR. ZARABOZO: Well, starting with the plans, I mean, the big recommendation for the plans is that you should be reporting in smaller units so that, for example,

the California case that we used last time, it would be you do, in fact, have to report for 11 markets instead of the one that you're reporting now. So the greatest expense there is with respect to records requiring medical record extraction. So that would be the additional expense there.

And then if expansion of the Health Outcomes Survey, the plans pay for the Health Outcomes Survey, so that would be an additional cost, and I know John wants to say something.

MR. BERTKO: I was just going to say that all of the big plans with good data systems report it down to the individual level, and so it's some amount of work to re-cut these things a lot as opposed to one big dump, but it's not new data collection. It's just data aggregation reports.

MR. ZARABOZO: It's differently reporting the data, yes, because --

MR. RICHARDSON: And that's what I was going to add, is in terms of the outcome measures, anyway, the main cost for plans, and assume they would pass some of that along to the providers who are participating in the plan's network, you can either look at it -- if you look at it from the CBO perspective, is it already in the baseline, and CMS

has said for a couple of years now that they're going to obtain encounter data. Of course, that could be this much or this much and the cost would expand or contract accordingly. But we're not sure what assumptions would have been made about how big or small that's going to be. But given the fact that they've already said that there will be some attempt to do this and that for other payers, large plans, as John indicated, may already be able to produce some of this information, you have to calibrate it that way.

On the fee-for-service side for those outcome measures, as I said in response to John's other question, CMS would incur the costs for doing that, as they do on the Hospital Compare mortality rate measures and readmission rate measures that are already posted for those providers using claims data.

There definitely would be some provider impact. I think the main impact, though, would be on CMS, which is why we focused that particular draft recommendation on them.

MR. HACKBARTH: Okay. I have Nancy, Arnie, George, Mike, and Bruce on round one questions.

DR. KANE: For slide 14, one question. What do QIOs do? I was under the impression they went around and

did some sort of quality assessments in fee-for-service, and I just wondered whether they are useful at all, or do they not do electronic --

MR. ZARABOZO: Some of the QIOs have, in fact, done this kind of comparison, which is the information that we gave last time in the mailing material from the GEM project. That was Masspro that did a national level for a slightly different purpose. Now, almost all of those measures that they used for fee-for-service were hybrid measures. In other words, in MA, you would have taken medical records, and they were just doing a straight administrative comparison.

DR. KANE: But is it possible to consider QIOs as capable of doing --

MR. ZARABOZO: Yes.

DR. KANE: So maybe that is --

MR. ZARABOZO: Yes. In fact, more than --

DR. KANE: -- the not available means it's just not being done right now, but there is an infrastructure already that could do it.

MR. ZARABOZO: Yes. That's correct.

DR. KANE: And my second question is on eight.

When you say appropriate geographic unit, you mentioned two types of geographic units and I just wondered what they were and are they kind of the kind of markets that the consumer looking at the data would say, oh, yes, those are real choices for me, or would they -- I just don't know quite what you meant.

MR. ZARABOZO: We're being intentionally vague here, which is --

DR. KANE: Oh. I thought you were.

MR. ZARABOZO: -- it's the appropriate health market area, and we mentioned that we had recommended in the payment report a certain geographic reconfiguration for MA. So you want MA and fee-for-service to be consistent and presumably consistent with health market areas. I mean, some people have definitions already of such market areas, but -- in other words, it needs to be reconfigured. We're not stating exactly how we think it would be done.

MR. HACKBARTH: The language struck me, also, and why you're being vague here. So my recollection is a couple of years ago, we looked at the appropriate geographic area, made a very specific recommendation on how to do that.

MR. ZARABOZO: For payment, yes.

MR. HACKBARTH: Yes. Why wouldn't use the same geographic --

MR. ZARABOZO: Well, I think if you had the payment set up in that manner, if you had geographic areas for payment, then presumably those would be the geographic areas for these kinds of comparisons. It would make sense that that is the MA geographic area and, therefore, that's the appropriate unit for comparison.

MR. HACKBARTH: Okay. This language is so vague, I think people will likely stumble over it, so we may want to think about saying, oh, we think that there is an appropriate payment area and it ought to be used for payment and for this assessment effort.

DR. MILSTEIN: Three very circumscribed questions. The first relates -- the origin is on the private sector side. Almost every effort to collect encounter data for managed care plans has been -- it has taken ten times longer than anybody thought, and about a third of the way through it, somebody says, gee, I wonder if it would work better if we were to strongly incentivize the plans to get it right the first time.

My question is, as CMS now has a requirement that

plans, you mentioned, submit encounter data by 2011, if the plans come up with a data file that's completely inadequate, is there any kind of significant incentive, you know, disincentive for them to do that, because that's historically what's happened on the private sector side over and over again when managed care plans have been asked for encounter data.

MR. ZARABOZO: That depends on CMS, as to what they would do if they had unacceptable data, essentially.

DR. MILSTEIN: But I'm asking you, right now, are there any contingency -- any incentives on the quality of that submission and the plans?

MR. ZARABOZO: Well, I mean --

DR. MARK MILLER: Carlos, there's no penalty if they submit the data in a way that isn't particular deep or defined --

MR. ZARABOZO: No, not as far as I know.

DR. MARK MILLER: So what we may want to talk about is whether we boost that recommendation. I assume that's where you're going --

DR. MILSTEIN: Exactly.

MR. ZARABOZO: Right, but part of the purpose, of

course, for the submission of encounter data is to confirm that benefits were received -- certain benefits were received, and to validate risk adjustment. So it is very important data, so I think that CMS would view it as a very important compliance --

DR. MILSTEIN: Thank you. The second question referred to your comment about if we were to get the HOS survey going on the fee-for-service side, it would be a couple years before we could look at deltas and two-year change in health status. As you were researching this, I remember you had shared with some of us -- I remember it -- the fact that there was this small residual unit within CMS that still retained -- it originally was measuring the HOS in the fee-for-service population and still maintained a capability of doing it and also had referred to the fact that they had a sort of a slice-in-time approach to also judging quality that didn't require the two-year delay. If this is not ringing a bell, don't feel you have to answer this, but since I thought you were aware of it, I wanted to know --

MR. ZARABOZO: Yes, but I think -- I'm not entirely recalling whether it was based on the CAHPS -- the

questions asked in CAHPS that were the HOS questions, whether that was what they used --

DR. MILSTEIN: Oh, maybe --

MR. ZARABOZO: And then the stopped asking those questions in the CAHPS survey.

DR. MILSTEIN: Thank you for clarifying.

The last question, do you anticipate -- your recommendations -- you also referred briefly to the fact that when you -- based on CMS's current system, the number of plans on HOS whose health status change is different than expected is very small, but obviously it is hugely dependent on how you set the calibration for what kind of a difference you allow people to see. In the next iteration of this, were you going to be addressing that issue of kind of degree of -- where you set the degree of difference? I mean, is that -- you referenced it as a problem, but I wasn't sure --

MR. ZARABOZO: Well, we suggested that if you want to show more differences, you would have to lower it, yes --

DR. MILSTEIN: Thank you.

MR. ZARABOZO: But we have not talked to the HOS people yet at CMS about that.

DR. MILSTEIN: Thank you.

MR. GEORGE MILLER: I want to follow up on Nancy's point on recommendation one. I was a little bit confused. I think I got the answer, but just to clarify that just a little bit, I believe the definition may -- a clear, as you said, Glenn, a clear definition would deal with it. But I guess I want to deal with the issue still of disparities and if we'll be able to tease that information out depending on the definition of geographic unit. If it's small enough, would -- I guess my question is, would we be able to determine that versus the larger group, and thus, I guess, the definition would help determine that?

MR. ZARABOZO: Well, I mean, once -- we have raised the issue that for some geographic areas, you will have very small numbers. The total number will be very small. So within that number, you cannot do anything -- if that's not statistically valid for results, then within that, you cannot have valid results. So in terms of, like, disparities, you might say, well, we'll look at a larger area. We're concerned about disparity, so we'll look at larger areas to get enough numbers to be able to make judgments about what is happening. So you have person-level data that enables you to look in different ways at the data

that you receive.

MR. GEORGE MILLER: But if I'm trying to determine what's a good quality provider for me and I can't get that data from the size, then I want to go to another -- a better provider. I mean, if --

MR. ZARABOZO: Well, we also -- I mean, in the same way that we said you could maybe use a three-year rolling average, the same would apply here. If you're talking a small geographic area, you might want to use a three-year rolling average. It may give you enough information to say, for the following kinds of people in this area, this plan performs in this way.

MR. GEORGE MILLER: I'm not sure that deals with the problem, but --

MR. HACKBARTH: So what I hear you asking for, George, is for information on disparities presented in a way to help guide patient choice, beneficiary choice --

MR. GEORGE MILLER: Right.

MR. HACKBARTH: -- as opposed to having person-level data that can be analyzed for research purposes or other policy purposes. I think those tasks are different and --

MR. RICHARDSON: I was just going to say, another issue that bears on this is that a lot of the data that we have on race and ethnicity, for example, is very poor, and the Institute of Medicine has released a report recently on how we could get better quality, pardon the expression, data on that out of the health care system, but we are attempting to address that through the EHR recommendation, where we suggest that the Commission, if it wanted to, could specify the types of information that should be part of every EHR that qualifies for a Medicare subsidy should capture that information, and the Department has already in its deliberations on what meaningful use criteria should be thought about this. I don't want to say this is original necessarily, but that's where -- and to the extent that there are small numbers and you want it to be relevant to an individual making a decision in a relatively local market area, if you had better information on more of the population, then some of the small number issues might go away even in a small area, and so that's how those two could work together.

MR. GEORGE MILLER: It's an access issue, also.

MR. ZARABOZO: There's also a separate report on

disparities reporting on quality indicators. As we mentioned, MIPPA had that provision, so there's more coming on it which HHS is doing, yes.

DR. CHERNEW: I just want to make sure I understand recommendation one. If an MA plan serves multiple geographic areas, under that recommendation, they would be required to report separately all of the different quality things that they report. So if they do HEDIS now for the entire plan, which could be the entire State, and now there were five market areas in a State, under that recommendation, they would have to report five different HEDIS measures.

MR. ZARABOZO: Yes, because right now they would say, for example, 80 percent of our diabetics do get eye exams, but, of course, it varies from area to area, so it might be --

DR. CHERNEW: Right. And so if they're doing, for example, the hybrid method, they would have to do the hybrid method --

MR. ZARABOZO: Correct.

DR. CHERNEW: -- in each of their market areas.

MR. ZARABOZO: Right.

DR. CHERNEW: And so some of their measures are medical review. They will have to multiply the medical reviews by --

MR. ZARABOZO: Yes.

DR. CHERNEW: And so the last question is, if they -- you have an example in the chapter about Tallahassee, right, and where they only had a few -- some of the plans only had a few people in Tallahassee. Would they have to do this for market areas that were sort of on their fringe that they didn't have -- so say they had 95 percent of their people in one area and there were a few that were kind of living -- how would --

MR. ZARABOZO: Well, see, in that case -- what happens often now in the Medicare.gov, the health plan, the options compare, many measures, they say, not enough information to report on this measure. So in that case, it would probably be that in Tallahassee, there's not enough information. You could say this plan overall in Florida performs this way. We cannot tell you how it performs specifically in Tallahassee, something like that.

DR. CHERNEW: So if I understand that, there could be a minimum -- you have to report in all of these different

market areas provided you have more than X-number of people in those market areas. That's the type of thing you would say.

MR. ZARABOZO: Right.

DR. STUART: I also had a question on one, and I have a suggestion, and that is appropriate geographic unit would have to be explained in the notes and it just sets everybody off. So let's call it local market area, because that's what you talk about in the text, and then you could explain that in the notes, too. And if we can't say exactly what that should be, particularly if it's contingent upon payment area designations, I think that's fine. But at least let everybody know that when we're voting on this, we're voting on something that we read in the text that says local market area.

MR. HACKBARTH: The reference "local market area" to me is vague, just in a different way, and what I'm saying to Mark is that I'm a little puzzled about why we don't just say the payment areas that we recommended in our report dated such and such, when we described how we got to them. It seems to me you want to sync up payment rates, information on quality in order to facilitate beneficiary

choice. Is there something that I'm missing?

MR. ZARABOZO: No, I think that's fine.

DR. CHERNEW: For example, the sample size requirements that you might come to when you -- I don't know how big the payment areas are, but the sample size requirements that you might come to when you worked through what's needed to get valid quality measures might push you to a different market area than you might have wanted to do when you -- I'm not saying it did, but it could, depending on --

MR. HACKBARTH: Yes, although there is, of course, a tradeoff there. If what you're doing is expanding the area to create numbers for your "n," you're also getting a more diverse delivery system where their performance distribution is probably broader, too, and --

DR. CHERNEW: That's round two.

MR. HACKBARTH: That's round two.

[Laughter.]

MR. HACKBARTH: But we just finished round one. Bruce is the last one, so --

[Laughter.]

MR. RICHARDSON: I don't want to get in the middle

of that --

MR. HACKBARTH: John has a round one-and-a-half comment.

MR. BERTKO: I'm going to follow up just with that payment area one, because if you follow through some of the things being proposed, it's payment areas plus quality bonuses, then it makes complete sense to match up the payment area no matter what happens. And if you're too small, you're not eligible for a quality bonus, which means you fold your tent.

MR. RICHARDSON: I just have one comment. You could also expand time, of course, as well as the geographic area, and we talk about that in the paper, do something like a three-year rolling average within that area, which allows you to get more people longitudinally as opposed to geographically.

MR. HACKBARTH: Let me ask -- I think this is a round one question. I'll rule it in order. So would you put up 14? For some reason, when I looked at this for the first time as you did the presentation, a bell went off in my head. On both sides of this, for fee-for-service Medicare and MA plans, we're talking about a distribution of

performance, and that's especially true in fee-for-service Medicare. For some of the big network private MA plans, again, you're going to have a broad range of performance.

So one approach to that is just calculate the average or the median and report that. And on the private side, I guess at some level, that makes sense to me in that they said, we're accountable for the quality here and so maybe that's okay.

Reporting one number, one average number as representative of the quality in fee-for-service Medicare, given the huge range in the distribution, almost seems like more data and less information. If, in fact, what we're trying to do is guide beneficiary choice, what does one average number mean on fee-for-service Medicare?

Have you wrestled with this at all, about how -- our goal is to provide information to guide choice. How do we deal with this?

MR. ZARABOZO: Well, I mean, we -- on a small level, the mammography screening and the cost sharing, you have differences in fee-for-service Medicare as to whether you have supplemental coverage or you don't have supplemental coverage. You have different -- so, I mean,

you could say, well, actually, maybe you should report by category in fee-for-service, those with supplemental coverage, those who don't have it. So there are many ways to cut the data. I mean, it's an important point.

MR. RICHARDSON: The other thing that we've thought about, going back to the slide I presented on the three different audiences, you could have different representations of the results for the different audiences. But to your point, if a range of values more accurately captures what's really going on in fee-for-service and you thought that beneficiaries in making decisions could filter that information and use that, that's really where the rub is there. Now, for the purposes of policy makers and other more sophisticated audiences that might be able to do that, then that's certainly something you can look at.

MR. HACKBARTH: Have private payers wrestled with this at all, or Jay, do you have any --

DR. CROSSON: Well, I don't know how much light it is. I'm just saying if what we're doing here is basically comparing a plan in a geography with all the fee-for-service providers in that same geography, I don't think you can get much better than that unless you just scrap that basis for

comparison and compare delivery systems in one geography and in another geography. But then in fee-for-service, you get down to the problem of what's the unit of measurement and how accurate is that and how many things can you measure at that level. I think part of the confounding thing is that the basis of measurement here is plans and then an artificial geography created to compare to the plan when, in fact, that range of performance is a range of delivery system performance, or deliverers' performance, provider performance.

MR. BERTKO: Yes. So, Glenn, I'm going to use an analogy here. It's almost like on educational testing results. You can compare school districts, but for a parent, you want to look at the individual school. I think we're at the school district level, and I was mentioning to Mark, I just sat through some efforts -- I heard about efforts in Minnesota and they're getting mandatory reporting down to the provider level. So I think maybe there are other entities out here that are going to do that second part of the job that everybody around the table would want to know. It's just I'm not sure that's our job or the job of CMS in this particular example.

MR. HACKBARTH: You know, maybe at some point it's -- you have online tools for beneficiaries to look at these data. They see in fee-for-service the average number is this. If we could refer them to the detailed provider-specific data within fee-for-service and have that in sort of a seamless way where people can look behind the average, maybe that would be helpful.

MR. ZARABOZO: Yes, and particularly say that there is a lot of variability within this area, so you really should look at the provider differences here, for example.

DR. MARK MILLER: Doesn't some of that exist in the sense of, like, the Hospital Compare, the Nursing Home Compare?

MR. HACKBARTH: Yes.

DR. MARK MILLER: I mean, so in a sense, you can look at your area and then --

MR. HACKBARTH: Okay. Let's see hands for round two.

MS. BEHROOZI: This is actually just kind of coming off of what George is talking about --

MR. HACKBARTH: Okay. Go ahead.

MS. BEHROOZI: -- what's the purpose of doing this? I feel like all it's really about is the extra money for MA justified by higher quality. So it's not really about individuals making choices because the individual is more likely to make a choice based on the extra benefits than on generically should I stay in fee-for-service rather than go for one of these plans where I'm going to get the extra benefits. So, you know, it does feel like the individual choice thing is really very different -- qualitatively different. It kind of doesn't belong on the same page, whatever that means. Wherever that takes us.

MR. HACKBARTH: Okay. So the second round, and remember before you put your hand up, I'm going to ask which of the recommendations you favor, which of the recommendations you have concerns about. John?

MR. BERTKO: First off is a wide-ranging question or comment, which is the timing on all this. Just thinking through here, this seems most contingent on CMS getting enough money to do this, and my suggestion partly is that we list them not with defined dates and times, but something like two years after the appropriation is passed, because I was thinking that suppose you had an appropriation even in

early 2010. CMS doesn't have the people and they have to go out and do the contracting, and then it would collect the data, then it would test and field test what was going on and stuff might be available at the earliest sometime in 2012. So there is this big timing issue.

And then related to that is the comment earlier on the lab tests. It's almost like -- I mean, I think maybe it was Peter who said, wake me up when the EMRs have arrived. I kind of -- I mean, it's going to happen, but the question is when. If we want to have lab test data in there, which I think is really, really useful, we want to say, do this -- include this two years after you have authorized the billing form to collect the lab data. I mean, I think you said it more tactfully, John, but there's no way you're going to get the lab data from doctors' offices and hospitals unless you put it on the payment form because then they get paid when they submit it with a full form, not any other way.

DR. SCANLON: An incredible piece of work here, so thank you. I'm supportive of the recommendations, but I'd like to sort of think about two phases in some respects. I mean, I think that if you look at this, in some ways, what we're getting is a quilt of quality measures. I mean, we're

picking up scraps here and there. We're forcing people to produce some more scraps and we're going to put them together and this is going to be our quality measurement, okay. Right.

And I think that, I mean, following up on what Peter said about EHRs and John just repeated it, if we don't get demanding, we're not going to see them, okay, and that's what we've got to do here. We're investing $35 billion, roughly, sort of in EHRs, ten times what we were talking about this morning with respect to medical education, and so we've got to get a return for that investment. And I think that if we are insistent, we will. If you think about what EHRs could do in terms of the transmission of data, you could have a whole different perspective on what's possible.

And just building off of what John said in terms of payment, HIPAA, sort of from 1996, one of the promises of it was the administrative simplification. We were going to standardize the claim and it was going to be so easy for everybody to send in claims. Well, it didn't happen. We have a claim and then we have attachments to claims. And since 1996, we've decided we need to do quality measurement. And so we have quality measures that people specify, but you

listen to providers and they'll tell you 17 different payers want the same measure but somewhat differently, a different denominator, different numerator.

And so what we've got to think about is how can we take advantage of the CHR to standardize the information that comes in on a claim, provides the building blocks to measure quality, to measure performance, to be able to risk adjust, and I think those things are all possible, and I think that this is the point where we've got to do it because if we don't, if we wait until EHRs have sort of more prevalence, their immediate response is going to be, oh, we can't do that. We've already programmed the systems and it's going to be impossible sort of to change things. So I think that that sort of would be my primary focus.

The only thing about the recommendations that I would differ with a bit is the issue of using sort of -- I think it was tied to the meaningful use recommendation -- was the idea of getting demographic data. I don't know what demographic data we should be getting from providers versus what demographic data we should have otherwise. The Medicare program already has sort of good age and gender information. To have providers send in information that may

conflict with that and create sort of problems from an analytic perspective, that doesn't seem to gain anything.

Race and ethnicity, the National Committee on Vital Health Statistics issued a report about three years ago, or three or four years ago, where they looked extensively at the issue of race and ethnicity, how complicated it is to actually capture that correctly, because -- I mean, particularly ethnicity. You've got sort of a whole series of questions about that.

The issue there is get it once right and use it, as opposed to again sort of having the potential for too much conflicting information to come in and have people discount things that you say because they say, well, your data, it wasn't really there for payment purposes and it's not reliable. I think we want to say to Medicare, invest the money in getting the right demographic information so we can use it for all the subsequent analyses that we're going to do.

MR. HACKBARTH: On your first point, Bill, about EHRs, one approach would be to say we don't do anything. We don't do any of the short-term stuff. We focus just on getting EHRs set up so we can do this in an automated way in

the future. I don't hear you saying that. You say, yes, let's do some of the pre-EHR stuff, but you want to hit harder on the importance of getting this right in EHRs.

DR. SCANLON: Right. I mean, it's both. I think in the short term, we need this information, and in the longer term, providers will get relief in terms of being able to use their EHR to submit this information, and it will all come sort of automatically. I mean, that sounds naive at this point in time given where EHRs are, but it's feasible. I mean, we know that technologically it's feasible.

MS. HANSEN: I think the one thing relative to the meaningful use, I appreciate John's segment pointing out how the age demographic is something that's collected now, but what's often not cut finer is the 75 and then the 85-plus. So if we're going to start establishing that baseline now, I really feel very strongly to take up on that recommendation on number four to really -- or I think it's number one -- that specifies the need to make sure we have those cut points, because I think even clinical recommendations is for the 65 and older. So if we start collecting that way, we can begin to track the data this way.

My only other comment has to do with I appreciate the fact that you identified three different audiences to whom this quality information would occur, and when I think about the beneficiary aspect and the star system that has been identified, I'm curious, because again, the desire to make it useful for people, have there been any studies about the value of the star system so far? I know everything was moving in that direction, but have people really used it to have any meaningful choice as a result of seeing this rating system?

MR. ZARABOZO: Well, part of the reason for the star system was because that's how CMS had done some focus groups and that was what was most easily understood by the beneficiaries. So they're putting a lot of effort into the star system. Now, whether people use it or not -- apparently Herb knows.

MR. KUHN: You know, I haven't seen the analytical work, but what I just know anecdotally is each and every year when CMS has the open enrollment period from mid-November to the end of December for the PDP plan specifically, and also with the MA which goes into the following year, the State Health Insurance Programs, the

SHIPs, who get funding from CMS who are really the counselors that help people choose the PDPs use that star rating system heavily. So anecdotally, there's a heavy reliance on that. So they've found it useful and very valuable.

DR. CHERNEW: Academic literature on the response to report cards in general, not necessarily this particular star system, is that it moves a relatively small percentage of people, but you get sort of different studies doing different approaches. You get a relatively small percentage of people to change. Now, some people, of course, would have chosen the thing that had a really good rating anyway, so they wouldn't have changed, and so you get a small but statistically significant effect in most studies.

DR. MARK MILLER: I thought the other thing the literature says is that it often compels the provider or the plan to change.

MR. HACKBARTH: Jennie, did you want to say anything about where you stand on the recommendations?

MS. HANSEN: Yes. I'm generally supportive.

MR. HACKBARTH: Okay. Peter?

MR. BUTLER: I'm supportive of my recommendations,

but I would suggest a little bit of the emphasis. I think Mitra highlighted the kind of what are we trying to do here in the beginning, compare MA plans to fee-for-service plans, and you say, well, it's kind of tough to do and we're doing the best we can. But while we're here, the more important issue probably is building and supporting some infrastructure within CMS and getting that going now because measurement will be a key part of the future, and if we delay on kind of getting momentum about that, we'll never be able to do this. And so I do think that CMS's role in this and what they ought to be doing now to get ready for it is as important as the specific questions that were asked as a part of this effort. So I would just rank order that a little higher or finish with it as part of our recommendations.

MR. HACKBARTH: Anybody else on this side want to comment on the recommendations? I will interpret silence as assent if I don't hear anything.

Bob? Let's go down this way.

DR. BERENSON: I strongly endorse recommendation eight, which is the one that says provide adequate resources or all sorts of bad things will happen, and I would include

the couple of pages in your background paper which identify the limitations of these comparisons and would include the discussion that Glenn and Mitra had, which I concur with, which is I don't think most beneficiaries look at how is the fee-for-service system in my area doing compared to MA as sort of a threshold question. They ask, do I want to change from my particular circumstances to an MA plan.

And so I -- I mean, if we wanted to get the first part, I mean, the other part, which is for policy makers, how does MA compare to fee-for-service, we would have a completely different sampling approach to getting that. We wouldn't have to set up all that we're setting up.

But we're mandated to do it and so I think we should, but I would emphasize you have to give CMS adequate resources and here's what could go wrong if you don't and amplify that.

I strongly endorse recommendation seven, which is the meaningful use one, and I think that's where I'd agree with Bill. We want to get ahead on that one, and so I'm not wildly opposed to the others. I think we have to move, but I would minimize burden in this interim period.

So to John's, we could require doctors to submit

their lab data, but it's not easy if you're not electronic. You have to match the lab test that comes back two days later, or a day later, with the claim that you had at the time of service. So Herb's suggestion of using G-codes doesn't work for lab very well. It is a real cost to a practice, and I think some of what we're asking the plans to do would be real cost to the plans for a short interim period, and so I'm not being negative about all the recommendations. I would be conservative on how much we're asking at this point plans and providers to comply with.

MR. HACKBARTH: Are there specific things that could be changed in those other recommendations that would make you feel more comfortable?

DR. BERENSON: I'll look more carefully, but I wouldn't be going to sort of requiring lab data submission, I guess, at this point. I mean, the whole value of electronic health record reporting is going to be we can have meaningful clinical measures and not have to rely on administrative data, and here we're going to sort of say, but the best part of administrative data is lab data, so we're going to go there. I mean, I assume we'll continue to use lab data in some circumstances, but with a lot more. So

I guess I would question whether we want to go for requiring that. I'd like more discussion or more back-up to convince me that it was worth doing that to provide that data.

On most of the others, I'll look again. I think I'm in support of the others.

DR. KANE: Yes. I mean, overall, I think I'm supportive, although I was thinking on the Health Outcomes Survey data, if it doesn't measure distinguishable differences at this point, should we really require it to be prepared for the fee-for-service population if we don't see much variation even within the MA plans? I guess maybe before we say it should be collected in the fee-for-service population, should we test and see if it really is going to be meaningful before we say it should be rolled out for everybody? I mean, that's just sort of a concern I have. If it's not picking up anything in the MA, why do we then turn around and say, put it in the fee-for-service?

MR. HACKBARTH: I think this is worth spending a minute on, and I'll ask Arnie and Carlos to jump in here in a second. My understanding, my rudimentary understanding of this is that using 95 percent confidence intervals, using that as the test, HOS has not picked up significant

differences among plans in their performance with these sample sizes. And so in order to make it a more discriminating tool, you either have to have much larger sample sizes or depart from the 95 percent threshold. I think that's the issue.

Now, totally out of my element, I don't have anything more to say.

DR. KANE: Well, I think just simply, rather than saying they should do this, collect and add it, say we should test further whether it will develop meaningful data, and then if it looks like it's feasible, then to go ahead and roll it out to the fee-for-service population, as well. That was sort of my draft recommendation, too.

And then my only other comment about all of the recommendations is that I think the beneficiary -- I'm sure they're interested in plan versus MA, but I think they're on different issues than we're able to collect here. I think they might want to know, you know, what do I not have to pay for out of pocket, or what does my premium do or my drug plan do. I mean, there's a lot of things a beneficiary wants to know about a MA versus fee-for-service that isn't in here.

But with respect to what this stuff measures, most of it's around how their underlying providers behave, and so I think -- I'm just wondering if our recommendation shouldn't be much more tailored toward what does CMS need to know to award bonuses and what do providers want to know with respect to whether they're going to win a bonus rather than what do beneficiaries need to know, because I think the beneficiary really wants to know how is the provider that I want to -- are they in the plan, and then how do they do relative to other providers.

Maybe that will just simplify some of these things, because I honestly think a beneficiary is interested in different questions when they're choosing between plan and MA, but then there's a lot of very granular things they want to know about their providers, and so maybe that's a whole other set of quality measures. Their fee-for-service comparison questions are different and they're not quality measures, they are benefit and financial measures. Their quality measures are not MA versus fee-for-service. They're which hospital or doctor do I want to pick.

So I guess I'm just feeling that this audience, the beneficiaries, could make this -- if we could take them

out as an audience for MA versus fee-for-service comparison and say maybe we're really just talking about CMS and the providers themselves, am I going to get a bonus, because what the CMS wants to know is are these plans really adding value over fee-for-service, especially when the providers are exactly the same, and should we be giving a bonus, because if the providers are exactly the same, are the plans adding some value?

So here, this is a great quilt, as we've described it, and I agree, but I don't think it necessarily thinks about the needs of the three audiences, and it might just be a slightly retweaking the way you present it to get there.

MS. HANSEN: Glenn, can I jump in on that? I think that's a point, Nancy, that makes absolute sense when what is it that a fee-for-service beneficiary is looking at. The CAHPS is about the provider per se. And then what doesn't get measured when you're in an MA plan are some of the other kinds of things, like the care coordination stuff that might come about. So there are slightly different products that are built in implicitly into some of these.

So I don't know how you get at it, but I think your point, and I think what Bob said, also, is what are

people looking for. And so somehow we've kind of maybe clumped them a little bit too much together rather than understanding what people are getting measured for.

MR. HACKBARTH: Would you put up 20 for a second? So the measures that are here seem to me, Nancy, as potentially measures that do begin to discriminate between the plan performance as opposed to just the underlying provider performance. These are areas where you might reasonably expect to see a difference in a really well managed plan.

And so it may be that part of the issue here, when you're thinking about the beneficiary perspective, is what you highlight, you know, things that are buried in a mass of data and they might find it difficult to navigate through that. But if you have a section, here are measures where plans might reasonably be expected to add value and here's how your plan does compared to fee-for-service, that might be useful.

DR. KANE: Yes, sort of as a way to kind of slightly rephrase some of these recommendations, to say for the beneficiary comparisons, this data set, we recommend. And that will require a different level of sampling and

blah, blah, blah than for the CMS thinking about does a plan deserve a bonus or not, and might just make it easier, in effect, to think about how much data you really need.

DR. MILSTEIN: Overall, I'm very supportive of these recommendations. I thought they were just wonderful to listen to as they were unfolding. So my suggestions are really, I will call it potential small refinements to what I think is basically a great set of recommendations.

First is I do think we shouldn't -- I think we should consider in the recommendations not so much resolving the argument as to whether or not beneficiaries should be able to see differences of 0.05 or 0.10 or even 0.20, because I think the research evidence suggests that people vary in kind of what they -- how much noise they're willing to tolerate in difference comparisons. There's some consumer research on this.

And so I think we should maybe want to consider the notion of allowing the user to dial it, you know, dial it up. So if they're content with -- if they're saying, oh, I don't want to see any differences unless they're significant at 0.05, they can do that. I think that's what Michael would want, whereas I think I talk to my mother and

she'd be actually grateful to see differences about which one was 80 percent certain. That's in the eye of the beholder and user. That's why I think rather than resolve it in a way that draws a lot of criticism is to allow flexibility on the part of the user.

The second small point is that -- it's a point made by others, but I think what people want is the ability to essentially consider relative performance -- to drill down, because that allows you essentially to have a dual picture of am I going to gain or lose if I drop in or drop out of Medicare Advantage, and if I use my current provider, how are they -- it's a combination. It's that dyad that I think is the most relevant. So I think we don't want to overload this with a reminder that consumers are interested at the doctor and hospital level, but if we can sandwich it in there, it would be terrific, because I think that's the evaluation question that most people want to know.

The third point I would make is if you look at the history of proposed investments in quality information, a couple comments. Once the information is gathered, everybody agrees that the value of the information makes the cost of measuring it cheap. That's been almost everybody's

experience.

And the second comment I would have is it's always cheaper than the people think it will be who have to pay the price, whether it's providers or plans, or in this case, taxpayers. You know, for example, there was an article this week in the Wall Street Journal on the Pennsylvania hospital performance reports, which are by far and away more demanding than any other hospital reporting system in any of the other States, because the hospitals have to report not just administrative data, but a significant amount of clinical information. And if you look at the beginning when that started, people were estimating how much it would cost, how much it would cost the hospitals, and the estimates from the people who were going to have to collect the information turned out to be about 3X what it actually turned out to be once it was routinized. And so I think whatever the cost estimates are, it'll be cheaper once it's in production and it'll be very much worth the price, because the comment has been made before, the cost of ignorance is all around us.

The fourth comment is, and maybe this is more of a question, but the Health of Seniors Survey was what I'd call sort of an early generation Health of Seniors Survey and

there have been subsequent advancement in the methodology such that now it has a way of getting over what's called ceiling effects, you know, where you can't identify fine gradations in change in health status. And so it would be helpful if this report could address whether or not, as long as we're reviewing all this, whether this is a moment in time to consider the sort of next generation Health of Seniors, that it has a way of, based on the early responses, homing in with a subset of questions that are geared to the general health level at which the respondent is functioning.

And last but not least, this issue of should we just wait for electronic health records or should we push ahead with doctors and labs having to report lab values and V-codes, you know, should we consider sort of a trigger structure, since that's popular these days, where essentially if physicians put in electronic health records that meet a high meaningful use standard, then they are spared the requirement of facing a mandatory -- a requirement that they report a lot of V-codes and/or submit their lab data. So it becomes yet another motivator for physicians making this migration that we realize would dramatically improve our ability to report on quality at

multiple levels and to do it a lot more cheaply than we are doing it now.

MR. GEORGE MILLER: This is such a fascinating discussion. I learn a lot just by listening to all of this. But I do want to go back to Mitra's comments concerning the quality issue, and so I've got more of a question concerning the recommendations, and I think I brought this up last month.

If we determine what meaningful value of quality is, then can we tie that to whether a MA plan continues to be funded? I guess I'm concerned about the additional cost for the MA plan to the Treasury. So how do we define that meaningful value for the beneficiaries? We have that program because they get additional benefits. Well, if they hit some standard, then maybe they get to keep all of it. But if they don't, then what do we do and what do we recommend? I don't know if the recommendations speak to that at all, but since Mitra brought that up, I thought this would be a good time, because then we're providing a service to the beneficiaries because that's why they would choose to go into an MA plan, because of additional benefits.

MR. HACKBARTH: You're right that the

recommendations don't address that.

MR. GEORGE MILLER: Right, but she teed it up, so I thought I would --

MR. HACKBARTH: And, in fact, we don't address it in fee-for-service Medicare, either. You could say that providers who are below some quality threshold ought not be able to participate in traditional Medicare, but we haven't gone there, either. That's not to rule it out on either MA or fee-for-service as a place we may want to go in the future as we develop more robust tools for assessing quality in each sector, but it's sort of outside what we've been -- the Congress has been willing to consider in either MA or fee-for-service to this point. So that's why we haven't explicitly addressed it here.

Mark?

DR. MARK MILLER: Remember, this was -- I think I've got this right -- the MIPPA had us do two reports. This is the second. The first one went out in June 2009 report, and in that report, we said, you know, our basic posture is that you should have a neutral payment system between fee-for-service and managed care, but we also said, over the long haul, if you can compare the differences

between fee-for-service and MA, which is what this report is supposed to do, you could, in fact, pay managed care plans more if they're better than fee-for-service in their area.

So without necessarily doing a hard vote recommendation, this discussion was included at the end of that report, is that correct, Carlos?

MR. ZARABOZO: That's right, and we mentioned it again here in the mailing material, in the history.

MR. HACKBARTH: Of course, we've also said that Medicare -- the government ought not pay private plans more than it would have incurred in traditional Medicare, and so the whole context for MedPAC's view on this is that the overpayments are not warranted unless, as Mark says, there's demonstrable improvement in quality. Other than that, we shouldn't pay more than traditional Medicare.

MR. GEORGE MILLER: But we are currently.

MR. HACKBARTH: We are. We're on the record as definitively as anyone can be that we shouldn't be.

MR. GEORGE MILLER: Yes. So what do we do next?

MR. HACKBARTH: Well, the Congress is considering the issue as we speak, and at least right now, both Houses look to be prepared to significantly reduce the payments to

Medicare Advantage plans.

MR. GEORGE MILLER: But I guess when I say, what do we do now, would it be appropriate if we addressed it in a recommendation now? That probably should be the way I should have phrased it.

DR. MARK MILLER: I think what, at least what I was trying to refer to and what I think you were referring to --

MR. GEORGE MILLER: If I'm off base, just tell me.

DR. MARK MILLER: -- is we're fairly pretty much on the record at this point for this. I mean, we're on the record as saying there should be equal payment or a level playing field between fee-for-service and managed care, and that was voted on, repeated many times by this Commission. I think a lot of it was before you got here --

MR. GEORGE MILLER: Right.

DR. MARK MILLER: -- but we've been on record for that. And then most recently, in this report, we said, over time, if you can measure these differences, then there's an argument for making a differential payment. So I think we're pretty much on record for this. I mean, we can certainly -- and I think, now that I'm thinking about it, we

do kind of pause in the draft of this report and say, remember where we've been. We can certainly repeat that, and I think it's even in --

MR. GEORGE MILLER: I think someone brought that up earlier. We might want to quote our previous recommendations. That may not be a bad idea.

MR. HACKBARTH: We could even bring -- in the March report we've used the box that summarizes past MA payment recommendations. We could even bring that in.

DR. MARK MILLER: So we could pull that in --

MR. HACKBARTH: Yes. So you're supportive of the recommendations, George, or --

MR. GEORGE MILLER: I agree with Bob on the lab issue. Generally, I am, but the lab issue, I think, has a structural problem about getting that information from physicians prior to EHR.

MR. HACKBARTH: Okay.

MR. GEORGE MILLER: So I agree with Bob.

DR. CHERNEW: I'm also probably pretty close to where Bob is. I'm supportive of the recommendations, but I'm not yet at Arnie's level of enthusiasm, though I appreciate it. It gives me hope.

[Laughter.]

DR. CHERNEW: As an economist, you need hope.

I have three concerns about the recommendations, loosely. The first one is the one that Peter raised at the very beginning which has to do with cost. I don't know enough about these to be able to say that the costs are a big issue or that there's ways of making it cheaper. I simply don't know. But, for example, if you are asking folks to replicate HEDIS depending on what the geographic area is, it could be implemented in a way that's more or less costly, and I would tend to try and advocate the less costly way, provided we thought we could get the information to achieve our base goals, recognizing that there will be some goals that we might have to give up in exchange. And I actually think the beneficiary using to compare stuff is less important than some of the other big policies, which is, I think, what Nancy said. So that is my concern one, is the cost.

Related, there are some design issues about these recommendations which are a little vague, but I think are important to get on the record. The first one is there's always -- in the design question, there's always these

sensitivity and specificity issues about how precise do we want the measures to be versus how narrow they are. So, for example, a bigger sample size works great, but it's expensive. So bigger markets can help you do that, but that doesn't give you the exact detail that you always want. So I would probably err on the side of somewhat bigger markets. Maybe the payment markets are big enough, and that's fine. I don't know the details.

And in terms of the reporting thresholds, I would tend to keep the reporting thresholds that they are now because I would worry about instability over time. If you have reporting of, say, 20 percent or whatever it is, at a point in time -- actually, I'm fine with that. I think Arnie correctly characterized my position.

But what I would worry about over time is if you allow it to report differences at a point in time, you'll see a lot of bouncing around over time and I fear what that will do is say something -- you know, you do this for years, the credibility estimates will really drop. If someone says, I just joined an MA plan. They were really good. Oh, no, wait a minute. Now they're not so good. Oh, wait. No, they're good again. And the data is always two or three

years lagged anyway. And so I think you have to do this in a way to hope that you can get stability and deal with having --

MR. HACKBARTH: Arnie could give you more hope.

DR. CHERNEW: I know. I will pause to let Arnie intervene.

DR. MILSTEIN: Michael is exactly right. The downside would be more instability, but there is an upside having to do with impact on the suppliers, whether they're plans or providers, of having customers that more often have value differentiators and therefore investing more in it. I mean, one of the reasons that, I mean, it's very unlikely that anybody ever used the HOS survey to choose a plan because it's set at the 0.05 level. Not all the plans were the same virtually. I think Michael is right, but there are offsetting considerations.

DR. CHERNEW: And another offsetting, of course, is various aspects of gaming that happens, depending on how you set up -- you know, they only focus on just these measures.

So I think we need some thought and so a little bit of caution, I think, is there, but I'm generally

supportive of the idea of more information.

My third concern relates to sort of systematic differences across groups that we don't measure well, which folks haven't discussed very much. There are two types that I worry about. One is case mix adjustment, which I think could be important, but I include in case mix adjustment not just clinical things, but socio-demographic things and other assorted things that I think it's important to at least be aware of. And so depending on the way in which you're doing the analysis, we just need to think about whether that's a bigger deal or not. I actually think across MA plans, it's not quite as big a deal because the MA plans on average have similar populations, although people might tell me that that's wrong. It's not an area that I've looked at very much. But I worry a bit about case mix adjustment things.

I also worry about an issue that Carlos mentioned just very briefly, which is many of these measures are actually -- Nancy said that they're measuring what your provider is doing, which is true, but they're also measuring what you're doing, many of these, and so if you were someone who was so enlightened to care about the cancer screening rates between MA and fee-for-service, that person is

probably going to get cancer screening in any of the systems, although maybe not. I do think the systems matter for that case.

But things like supplemental benefits and other things matter a lot in that area, and so I actually think that this is more useful right now, or I could see it being more useful more quickly in reporting to CMS about broad questions, even in feeding back to plans and providers about how they're doing. But I just -- the bottom line is, I'm supportive. I'm closer to Bob's level of support.

MR. HACKBARTH: Let me just pick up on this for a second, Ron. So broadly speaking, we've heard about two, maybe three different types of use of this information. One would be to guide beneficiary choice. A second would be to guide bonus payments for quality. And then the third would be sort of analytic purposes, examining differences.

What I've heard from at least some members of the Commission is some uneasiness about the utility for number one, guiding beneficiary choice. Some in favor, but a number of people fearing that's not going to be all that useful for that purpose. And so we'll think some more about that.

The first point I think you raised, Mike, was about the geographic units, and I want to come back. If, in fact, a principal purpose of this is to guide bonus payments to plans, it seems to me you really then want to match this to the payment areas.

DR. CHERNEW: And if you get the bonus a little bit wrong --

MR. HACKBARTH: Yes. And so in terms of the geographic unit -- I'm sorry to be pounding on this, but I really think we ought to get away from the vague language and say that we want to sync this up for bonus payment with the payment areas previously recommended by MedPAC. I think that really makes a lot of sense.

MR. ZARABOZO: Just to help Mike, we did -- I mean, in terms of what we said about the geographic unit, it was MSAs, but you would not split up a State, and then the non-MSA areas would be grouped into the Health Service Areas, of which there were 417 -- is that the number? The HSA is 417? Anyway, they're geographic units determined by patterns of care. So they're relatively large areas, in other words.

DR. CHERNEW: I think I could convince you, if

you're interested in bonuses, that you could relatively reasonably analytically have a plan-specific bonus that allows you to look at the full spectrum of that plan's data as opposed to have to cut it down into specific areas, if that was your only goal. So it would be related to payment areas at some level, but it also would take all of the data. So this issue that they have some plan that has people that are too small an observation -- too few observations in an HSA, you don't want to throw those people out for the purposes of bonuses. You could look at that plan individually, because you want to do bonus for the plan specific thing. So I think analytically we could have a discussion about how to do that.

MR. HACKBARTH: Okay. Ron?

DR. CASTELLANOS: Well, first of all, I think you guys did a great job on this. I've been watching this for the last year and a half and you really have done a yeoman's task and I really appreciate what you've done. It's been fun watching this evolving from nothing to what it is today.

That being said, we certainly understand why we're doing it, because it was a MIPPA requirement. I'd like to talk a little bit about the beneficiary or the patient and

then the provider. I think Mitra hit it on the head. What are the beneficiaries going to look at? What's in it for me? They're going to look at it for cost. And a question that I'm asked an awful lot is, Doc, are you in the plan, because if you're not in the plan, I'm not going to join it. I hear that a lot in MA plans. I don't, obviously, not in fee-for-service. But I think that's a consideration.

How about the provider? Well, I think on the MA side, I think the MA plans have a hammer. I'm not going to pay you unless you do what I ask you to do.

On the fee-for-service side, I know Arnie suggested that we ought to drill down on the physicians and get them to do this. You know, this again is an unfunded mandate. I don't have any choice. I have a 60-plus percent Medicare practice. So I really don't have a choice. But there are a lot of places in the country, especially in urology, in Denver, for one reason, have less than a ten percent choice. You know, the hassle factor is becoming a real concern in the medical profession and I suspect that there's going to be some people, not just in urology but in other fields, that are going to say, you know, I don't need to do this anymore, and that's going to be a problem perhaps

with access.

I don't know what the real -- I think there are some significant benefits for the patient, because we're going to be able to see which are the best plans or the quality issues. But from an unfunded mandate, and then we're going to be talking very quickly later on this afternoon about ancillaries and excess money being made there, I'm afraid that this is going to be a significant -- may be a significant problem.

EHR, you know, that's only about 20 percent of the physicians are using that now. It's an expense, but not only expense but a very, very steep learning curve. I'm not sure how beneficial -- we have electronic medical records. I'm really not sure how beneficial it is to my practice. Thank you.

MR. HACKBARTH: Are there particular things, Ron, that you would like to see changed?

DR. CASTELLANOS: Yes. The one thing I'd like is the same thing Bob said, is the hassle factor. I'd like to get that out. And the big one there is the lab studies and reporting them. It's going to be an onerous obligation, both to the people with electronic medical records and not.

I support, in theory, in an ideal world, I really like what we've done. In a practical world where we live, the hassle factor is what bothers me on the provider side.

DR. STUART: I strongly support these recommendations. I'm not sure whose camp that puts me in, maybe Bill's. I mean, these are data that we've needed for a long, long time, and this is actually a unique opportunity for us because this is a Congressionally-mandated study. It's not just something that we kind of ginned up and said, oh, this is important. We were asked to do this and we're responding and so I think we owe it to ourselves to do a strong sell on this.

I think the differentiation between users is a little misdirected, in some sense, because I agree with Mitra that it's unlikely that most beneficiaries are going to go through this at 75 or 95 or whatever it evolves to different kinds of measures. I never thought in reading the chapter that this is how that information would be used anyway. I always thought that it would be used by CMS in the star system so that there would be some way of aggregating this information in meaningful ways. But unless you get it at the granular level, you can't do that.

And so I think that's a -- I think it's very important and I think that it will have positive impacts on beneficiaries, not just through their choice of whether to stay in fee-for-service or go to a particular plan, but it will also have an impact on the plans because of bonuses or because of using this. If you've got one star rather than four stars and you want to stay in this market, then you're going to have to change your behavior. So I think that this is very beneficiary-centric, even though it might not look like that at the granular level.

I do want to go back to a point that was raised by John, however. If we go through all of these recommendations, there's only one that mentions 2011 and that's recommendation three, and I think that the reason that it's in there is because that's what we were told to do in terms of the study date.

The reason I'm looking at John is that I'm, if I heard you right, I think you were telling us that we can't do this by 2011. So I'm worried about knowing that -- supporting something that we know in our heart of hearts is not going to happen, but recognizing that this was the mandate of the study that asked us what could be done by

2011. And so I guess I would say if we really don't believe it could be done by 2011, even if the appropriations for HHS were available on time, which they're not going to be, then maybe we should just back off and say -- use your language and say, well, we really don't think we can do this by 2011 as opposed to having that artifact.

And then, finally, I really agree with Arnie's point about having dial-up. I teach an advanced methods course, and when we get to this P equal 05, I say, there's no science in P equal 05. That's religion.

[Laughter.]

DR. STUART: And religion may be important, but it's not scientific. So being able to make distinctions on something other than P-05 is going to be really important. It's going to decide. Well, let's say that we did P-01. That's going to mean that we may not have to aggregate over time, which comes with its own problems.

So I'd like to think about that a little bit in terms of how we use this information. But, of course, that only becomes relevant if this thing is in place, so that comes back to my first point, to say that it's time. This is something that we've got to do.

MR. HACKBARTH: On this slide, what I heard you say, John, was it was bullet two that you thought was not feasible by 2011, or --

MR. BERTKO: No. No, I said both. Bruce heard me correctly, because I was kind of counting down, and Herb here can maybe make a better comment, but the money's got to come first, so presumably that's a 2010 appropriation. Then there are contracting rules, which I don't know much about, but I presume those would take three to six months. And then there are the actual getting the vendor and collecting the data.

So I would say it's not impossible to do bullet one, but it's near impossible and it's more likely that it would slip. I mean, I'm just guessing here now

MR. HACKBARTH: Herb, maybe you can help us out. I haven't followed this at one percent of the intensity that John has, but my impression was that CMS had begun planning to collect these data and it's not like they're at a dead stop.

MR. KUHN: Yes, and Carlos, you can help me. I think these are the line codes that they would get for lab values. I mean, they have begun the process of thinking

about how they would go implementing, so there is already some of the work that's already run up to it.

So, I mean, if we believe in stretch goals, I think we need to push pretty hard on this as we go forward. But, you know, the process on those line codes has already started. They've talked about it for years already. So this is not unknown to them in terms of the process they'd have to follow. It's just going through all the steps to make it happen.

MR. RICHARDSON: Could I just clarify?

MR. HACKBARTH: Can I ask -- excuse me for just a second, John. So what I'm trying to focus on, Herb, is bullet one as opposed to the lab values. I thought that CMS had announced at some point in the last, you know, six or 12 months that, yes, they're going to collect encounter data from MA plans --

MR. RICHARDSON: Right, but those data are not needed to calculate the measures that are referred to in the first bullet. Those would be already collected on an MA from HEDIS --

MR. HACKBARTH: Okay.

MR. RICHARDSON: But I would like to make a

comment about the fee-for-service side of that, which is that I think what John is raising is a concern whether CMS, which solely would be responsible for doing this, would have the resources to be able to do these, in some ways, of looking at the most simple administrative data only HEDIS measures by 2011, even at the geographic unit level that we're contemplating. I think to a large extent here, it's an IT issue in terms of the computing power and the resources to be able to do it, because, just to say for the sake of argument, they already have the claims data that they need in most cases. But then it's writing the programs to say, here are the specifications for these particular measures. We need to include these people and exclude those people based on diagnosis code, et cetera, et cetera, and then produce the results for some several hundred, let's say, geographic units.

And I think I would respectfully disagree about the feasibility of that. I think that CMS may, but ultimately they would probably be the best judges about whether they could do that with their current resources or how much more they would need or moving parts around.

MR. KUHN: It would take additional resources, but

there is a standard procedure they go through in terms of the change requests, the writing the new programming, the testing the systems, to get all the information out to the providers and others out there. So that's rather routinized. But it does take time and it does take resources.

MR. ZARABOZO: And this GEM project that we talk about is essentially -- that's what bullet one is, which is the computation in fee-for-service of the HEDIS measures, and they did ZIP code-level numbers, so it has been done. It could be done again using the QIO.

DR. STUART: When do we have to make the final vote on this?

DR. MARK MILLER: We are shooting for the next meeting.

DR. STUART: The next meeting? Has anybody talked to CMS about --

DR. MARK MILLER: Daily.

[Laughter.]

DR. STUART: Daily, okay. I take that back. It was a question about what CMS is telling you about this, whether --

DR. MARK MILLER: We can go through additional rounds and sort of sharpening up on the basis of these questions. We certainly heard issues raised about the lab values in this conversation, and go back through this with CMS.

It is a little bit awkward. I mean, the mandate says, tell us by 2011 what we can do. We can be much more careful in this report. I mean, we are making a big deal about the resources, and I think everybody agrees with that, and we can be much more clear in the report that says, you know, this is feasible, but unless it starts now, it's not going to make it, that --

MR. BERTKO: And I defer to Herb here. If it is most of the way along the way and there is only a small increment of resources, sure, that tips it in favor of getting done. But if it's a larger thing, I mean, these guys are stretched already.

MR. HACKBARTH: Jay? Karen, did you have your hand up? Do you want to leap in here? In fact, I'd like to know whether there's anything here that gives you pause, and I think Tom, as well, hasn't said anything. And Herb, I don't think you've said anything overall about the

recommendations. So I'd like to hear from each of you quickly, and then let Jay go.

DR. BORMAN: I'm impressed with the work that it's taken to get us here. My concerns would settle around the lab data and the medical record extraction in terms of putting burden on providers before they have the electronic tools to readily do that. I personally believe that the whole health IT initiative is one of the real tools that we have that by itself will, in a sustainable, self-propelling way, transform health care in the way that we want it to go.

I would not want us to do anything that casts a bad light for the physician office about embracing health IT. It puts that goal at risk over the long term, because once everybody has a truly interoperable, uniform health IT to access, then when somebody comes to my office and says they had a test yesterday, I know I can get the result of it. I don't have to reorder it in order to make a care decision today.

I think over the long term, that has huge potential value to change the way we practice without doing anything else, without getting into touchy areas with people, without trying to force people to do things, and I'm

just a little concerned that this lab value piece in particular puts that longer-range goal at risk. Otherwise, I think they're reasonable.

DR. DEAN: I'm generally supportive of all the recommendations. I mean, I have the same hesitation about the burden on small offices. We get a number of those requests from insurance companies. Every insurance company wants to do their medical management thing and they want lab data and it's a real headache. Nonetheless, it's obviously important data and I think it's important to let the word get out that this is going to be a requirement and that -- but I think we shouldn't push it too hard or too rapidly.

And I guess just finally, I would say I have some degree of skepticism about how many beneficiaries are going to directly use this data, although as Herb mentioned, the SHIP programs, I think, have been very helpful in our area and those folks know how to use this data. I think the average beneficiary is going to be a little intimidated by it, and I think my experience is they really don't use that kind of data very much. But if there's an intermediary that understands how to use the data and what it means, it probably would be useful.

MR. KUHN: I, too, am pretty supportive of all the recommendations. I think it's a good, comprehensive listing that gives us a good stake in the ground for moving forward in this direction of the real head-to-head comparison between fee-for-service and MA and trying to derive some value there.

I'm like Bob, though, and others have said this already, but CMS is starved for resources across the board, and so the fact that we have enunciated on each and every one of these and have a separate recommendation, recommendation number eight, that talks about resource needs, I think that's just wonderful and needs to be there.

And as we talk about this, again, I think, Glenn, you're right in terms of guiding beneficiaries' bonus payments and ultimately analytical purposes. All of these are going to be very valuable. But the issue here is that, as we've seen over time, when these are rolled up into composite measures or they're rolled up ultimately into the five-star rating system, which I suspect this is where this information will ultimately wind up, it does really -- the providers, nobody wants to be a one-star or two-star and they will use this information. They will drive performance

improvement in ways that I think will get us far greater advancements with the resources that are expended here. So this is valuable information.

DR. CROSSON: Well, I support the recommendations. I have a small part of me that's leaning towards Bob over here, because I do think that some of the recommendations represent temporary but necessary accommodation, not only to the request from Congress, but also to the fact that some of the current legislation anticipates bonuses which are based on successively each of these comparisons. Therefore, there has to be some basis to do that.

I do think, though, in the end, that anything that can be done to kind of move up the tipping point of the implementation of electronic medical records is going to make it -- I mean, it's a quantum change, an order of magnitude or more in terms of availability and cost of stuff. So that's sort of where I am.

I was listening to the commentary and trying to put what folks said into three different areas. One would be just general perspective. Other comments were, although they weren't always explicit, you know, could we please change the text to emphasize something a little bit more or

less than what had been emphasized.

And then I thought I heard four sort of a little bit more specific, could we just change this thing, and I thought -- well, I don't know if you want to discuss any of those, that they might be things that the staff could come back at the next meeting with a recommendation and say --

MR. HACKBARTH: Why don't you just quickly --

DR. CROSSON: -- here's how we address them. One was the one that Glenn brought up himself, which is to change the term "appropriate geographic unit" in recommendation one to something more reflective of the previous payment unit recommendation.

The second one was I heard Nancy say, I thought, that she would like to see recommendation two altered to make a recommendation which is to expand the use of HOS contingent on some feasibility assessment by CMS. At least, I thought I heard a specific --

DR. KANE: [Off microphone] Both feasibility and then it produces meaningful --

DR. CROSSON: Feasibility as a useful measurement, yes.

And then number seven, I thought I heard Bill say,

do we want to consider removing demographic data from the recommendation of information to be contained within the EMR recommendation. We didn't have much of a discussion on that, but perhaps we could come back at the next meeting and talk about that one.

And then the last one, which I heard in one form or the other from George, Bob, Mike, Ron, Karen, and Tom, was the question of do we really want to include this lab data thing, and I think it may be that it's going to be hard to bring any more facts to bear on that question, but I think that one also probably deserves some more discussion.

MR. HACKBARTH: Thank you, Carlos and John. More about this next time.

Our next session is on pricing services in Medicare’s fee schedule.

DR. HAYES: Good afternoon. Our topic for this afternoon is pricing services in the physician fee schedule.

Just to get our bearings, recall that Medicare’s physician fee schedule includes relative value units or RVUs that are intended to account for the relative costliness of three types of inputs that go into furnishing physician services. Those inputs are:

Physician work, that would be the time and effort that physicians put into furnishing services;

Practice expense, which includes things like wages paid to non-physician personnel working for physicians, other items such as rent, utilities, equipment, supplies, a few other things;

And, the third category of inputs would be professional liability insurance.

During this session, we will focus on the RVUs for physician work and practice expense. Together, they account for about 96 percent of payments under the physician fee schedule.

The overall policy question for this session is whether the RVUs are accurate and equitable. While relevant to all services, the question is particularly relevant to physician services because of the critical role that physicians play in the health care system and the concern in accurate payments can affect patterns of care.

The Commission has expressed the concern many times that unless prices are accurate, there is a danger that behavioral change in the practice patterns will become skewed.

Payment accuracy has implications for volume growth also. As you know, the volume of physician services has continued to grow. This slide shows a mini version of a graphic you've seen a number of times before. It shows the relatively low growth in the volume of evaluation and management services and major procedures but much higher growth in other procedures, tests and imaging.

Another reason to consider pricing of physician services has to do with the fact that the issue right now is timely. In November, CMS will request public comments on services in the fee schedule that may be misvalued. The Agency issues such a request every five years to begin a process known as the five-year review.

In 2006, the Commission made recommendations from a process standpoint on how CMS might improve the five-year review. Briefly, and I'm just going to run through this, we recommended that the Secretary establish an expert panel to give advice on services that may be overvalued; that the panel should have expertise in health economics, physician payment in addition to clinical expertise; that the Secretary should use claims and other data to identify services that may be overvalued because of volume growth or

other factors; and that the Secretary should review all services periodically.

We left on your chair a handout after lunch that has at the top of it, Chapter 3 and March, 2006 in the lower right corner. If you want to look in more detail at what those recommendations were about and some other recommendations the Commission has made about pricing, you'll find them there.

Anyway, so with the next five-year review about to start, perhaps these recommendations would bear revisiting.

Separately, a recent report for the Department of Health and Human Services offers evidence to reinforce the Commission's concern that the pricing of physician services can affect expenditure patterns. In a study of 10 high-growth services, payment was a significant factor in the growth of most of the services. For instance, in the case of polysomnography services, services known as sleep studies, the combination of payment levels and features of the billing codes for these services appears to have driven practice patterns in the direction of diagnosis of sleep disorders but less so in the direction of comprehensive care for the disorders as a chronic condition.

Finally, on this point of timeliness, let me just remind you that this issue of pricing of physician services came up during your planning meeting in July. There was interest then in taking up these issues during the current report cycle.

So, at this meeting, staff are seeking answers to two questions: first, whether you believe that we should revisit the pricing of physician services during this report cycle and, second, if that is the case, which issues in particular should we address.

Several pricing issues are discussed in the mailing materials for this session, and they are listed here: accuracy of estimates used to determine the fee schedule's work RVUs, physician work and whether it's defined broadly enough, accuracy of the fee schedule's RVUs for practice expense and, finally, pricing services furnished together during multi-service patient encounters.

If you choose to address these issues, it would not be to the exclusion of other work. The form of the delivery system remains important, of course, including work on options such as accountable care organizations that might move payment policy away from fee-for-service. In the

meantime, though, fee-for-service continues, and it's important for prices to be accurate in that part of the payment system.

Let's look now at the first issue, which is the accuracy of payments for physician work. For the fee schedule, physician work is defined as time and intensity. It's the time that a physician spends furnishing a service, and it's the intensity of effort per unit of time.

Focusing first on physician time, note that in determining the fee schedule's work RVUs, CMS has a time estimate for each service. These estimates come from two sources -- research conducted by William Hsiao and his colleagues at Harvard, that was in the 1980s, and then, more recently, a panel of clinical experts has provided estimates to CMS. This is a panel known as the American Medical Association and Specialty Society Relative Value Scale Update Committee, also known as the RUC.

To get some perspective on these estimates, note that they tend to vary by type of service. For instance, among broad categories of services, major procedures take the most time, an average of 188 minutes. That includes both the procedure, well, the procedure itself plus any pre-

and post-operative visits. Imaging services have some of the shortest times, on average, 14 minutes for the category.

A change in the time estimate for a service can lead to a change in the RVUs. The correlation between time and work RVUs is very high. Recalling that correlation coefficient can have a maximum value of 1.0, the coefficient for the relationship between time and work RVUs is almost 1; it's 0.9.

Questions about the time estimates have come from the comparison of the estimates with data from other sources. For instance, the physician time estimate for a colonoscopy is 30 minutes. However, published research on use of screening colonoscopy includes a much shorter estimate, 13.5 minutes. More broadly, research for CMS suggests that over-estimates of physician time may be a problem that applies to a number of services and not just limited to an isolated procedure such as colonoscopy.

For this report cycle, the Commission, while not determining RVUs, could consider the validity of the time estimates. This work could include review of research, literature and government reports. It could include the investigation of the availability of secondary data sources

and comparing those data to the time estimates that CMS has. We could also investigate the availability of data or approaches to collecting data that could be used as a substitute for the time estimates.

Now what about the other part of the definition of physician work, intensity? While time is directly observable, intensity, the difficulty of physician work per unit of time, that's more of a judgment call. For the fee schedule, intensity is defined to include three characteristics: first, mental effort and judgment; second, technical skill and physical effort; and, third, stress.

The question here is whether this definition is leading to payments that are fair, payments that are equitable. To address this question, we need to see how much intensity of effort is included in the payment for each service. For that, we can use the fee schedule's work RVUs, its physician time estimates and its dollar conversion factor. With these numbers, we can calculate compensation per hour which is just a way of looking at intensity in dollar terms.

It turns out that because of the work RVUs assigned to services, the fee schedule establishes

considerable differences in physician compensation per hours. The range of those differences is shown in a table that was included in your mailing materials, that shows compensation per hour by type of service. For this slide, we extracted several examples from that broader analysis.

I won't go through each of these examples, but let's just walk through one of them here. So, for an electrocardiogram, compensation per hour is $53 or 61 percent of the rate for an office visit.

We're using, in this case, office visit as a comparator because that's the most frequently billed service in the fee schedule. Then you can see below that the compensation per hour for the office visit itself is $87, and so on. I've got a couple of other examples there.

Looking at such differences, we can question whether the valuation process is fairly compensating physicians. Is the process producing an equitable outcome? For example, some might argue that the physician work accompanying an office visit is every bit as intense as the physician work that goes into interpreting a CT scan. Yet, as we see here, evaluation of a CT scan is more than 1.5 times that of an office visit.

Or, take the electrocardiogram. Yes, the compensation per hour for that service is less than an office visit. Still, it is fully 61 percent of the visit rate.

To make all of this a bit more vivid, we wanted to have an example, and some of you will recall a discussion that the Commission had previously on these matters, and I'll ask Tom's indulgence here. At the October meeting, two years ago, Tom made the point that the complexity he encounters as a primary care physician is very different from that of a proceduralist. The point was that in primary care it is often the case that the patient is someone who is elderly, who has maybe three or four diseases, limited income, no family. In such circumstances, the complexity comes in evaluating the needs of that patient, in constructing the care plan and in doing so in a way that achieves the best outcome.

Perhaps another way to look at this is to think about medical students and their decision of whether to practice as a generalist in primary care or, say, general surgery. In surveys, the medical students identify important considerations -- factors such as predictability

of work hours and control of a lifestyle. Perhaps the valuation of physician work should include some of these factors.

Just to conclude here, before I hand things off to Ariel and we go to several other issues, you have talked from time to time and, indeed, have expressed some frustration about the need for Medicare to pay in some way for the value of services. The difficulty here is quantifying value in the absence of better information on comparative effectiveness. So that's one possible destination, but we would need your guidance on how you would like to proceed.

Another place to go would be to focus on process. In 2006, you made the recommendations about improving the five-year review. With another review about to start, perhaps it's time to revisit those recommendations.

Yet another option is to expand the question, to go from the process questions you considered in 2006 and perhaps focus more on the mechanics, if you will, of how services are valued. That can include the specifics I talked about -- the time estimates and how the fee schedule accounts for intensity.

So there's a range of issues we can pursue here, and it's just a matter of saying which ones you would like to work on and where we can go with this.

So I'll turn things over to Ariel who will talk about some practice expense issues and some pricing of services furnished together.

MR. WINTER: Thank you.

Ensuring the accuracy of practice expense RVUs is important because, as Kevin showed on one of the first slides, they account for almost half of all payments under the fee schedule. It's worth pausing for a moment and noting the potential for interaction between physician work and practice expense. For example, an increase in practice expense for a service may reflect the substitution of non-physician staff or other inputs for physician work.

Practice expense includes two types of costs: direct costs which are non-physician clinical staff, medical equipment and medical supplies, and indirect costs which include administration staff, office rents and other expenses.

As you may recall, CMS uses data from surveys of physician specialties to calculate indirect costs. These

cost data currently come from different surveys and different time periods. For most specialties, the data reflect costs from the late 1990s. For 13 specialties, however, CMS uses cost data from supplemental surveys that were conducted between 2001 and 2006.

The Commission has expressed concern that using more recent practice cost information for some, but not all, specialties could cause distortions in relative payments.

For the 2010 physician fee schedule, CMS has proposed to use data from a new survey sponsored by the AMA and the specialty groups. Compared with the data that CMS currently uses, this new survey is a step forward because it provides more recent cost data, it measures costs of nearly all specialties and it uses a standard protocol for all specialty groups that is designed to derive and direct RVUs.

However, the Commission has asked CMS to provide more information about this survey's response rate and representativeness. We are concerned that CMS has not discussed its strategy to keep the specialty-specific cost data up to date in the future. One option that could be considered would be to require a sample of providers to submit cost data. Another option would be to consider

alternative ways to set indirect practice expense values that do not rely on specialty-specific cost data.

Now we'll talk about how Medicare pays for services often furnished together. CMS has developed a policy that accounts for efficiencies that occur when multiple surgical or multiple imaging services are provided during the same encounter. For example, when two or more surgical procedures are performed during the same operation, Medicare pays the full amount for the most expensive procedure but reduces payment for the other procedure by 50 percent. Similarly, when a provider furnishes multiple imaging services on contiguous body parts during the same session, Medicare reduces the payment for the technical component of the subsequent services by 25 percent.

These reductions are based on the logic that total practice expenses are lower when two procedures are performed together than when they are performed independently. However, this policy has two limitations: First, it applies only to surgical and certain imaging services, and, second, it adjusts payment for practice expenses but does not adjust for any efficiencies that might occur in physician work.

In a recent report, GAO reviewed pairs of services that are commonly furnished together, but those payments are not reduced by the current policy, by CMS's current policy. For example, they looked at pairs of interventional radiology and pairs of physical therapy services.

Based on input they received from contractor medical directors, GAO concluded that efficiencies when many types of these services are provided together because some of the practice expenses are not duplicated, and GAO estimated that Medicare could save over $500 million per year if the multiple procedure reduction were applied to these pairs of services. However, the AMA has raised objections to GAO's methodology and their conclusions.

The RUC has also been concerned about this issue, and it has formed a joint work group with the CPT Editorial Panel to examine services that are frequently billed together. Over the next two years, the CPT panel will be considering whether to combine 53 pairs of codes into fewer comprehensive codes, for example, CT of the pelvis and CT of the abdomen. If this occurs, the RUC would then value these new codes and forward the recommendations to CMS.

CMS has also recognized this issue. In this

year's proposed rule on the physician fee schedule, CMS noted that it has hired a contractor to analyze both physician work and practice expense inputs for services that are performed during the same encounter. CMS is also considering whether to expand the multiple procedure payment reduction or to bundle services together. At this point, it is uncertain whether these efforts will lead to changes in how Medicare pays for multiple services provided in the same encounter, and there may be an opportunity for the Commission to do its own research on this issue and provide guidance to CMS.

Now we'll mention some issues you may want to talk about in your discussion. First, should the Commission examine revisions to the physician fee schedule? If so, of the four issues that we've raised, which are the most important? Just to remind you, the four issues were the accuracy of physician work, how physician work is defined, the accuracy of practice expense and the pricing of services furnished together.

A related question is whether CMS has sufficient resources to undertake the kinds of changes we've talked about, and you may want to consider this as well.

Thank you.

MR. HACKBARTH: Thank you, Kevin and Ariel. It was an excellent job of framing some important issues. Let me expand the frame a little bit further.

So Kevin and Ariel have said within the existing structure here is a series of issues that we could look at on the work side and the practice expense side. From time to time, however, we've had commissioners say the problems with RBRVS are even more fundamental than that.

We've got a system that basically tries to estimate the input costs in producing a service -- the work and the practice expense and the professional liability expense -- and says the right price is based on how those inputs vary and does not consider the value to the patient or the value to society or shortages of particular types of providers. It's strictly focused on input costs. From time to time, we've had commissioners, Arnie, I think being one of them, saying this is not the right construct, that we ought to also be systematically trying to pay based on value, as one example.

Now the virtue of this framing of the issue, as Kevin and Ariel have just done it, is because it's working

within the existing construct. You can imagine getting a grip on this stuff, especially, for example, the accuracy of the time estimates. That's something you can really wrap your arms around. Broaden the frame to issues like value, and, boy, it's a much different sort of project, not just in terms of our effort but ultimately in terms of CMS's effort as well.

So, as we go around and people comment, one thing I'd your reactions to is how we deal with this. Do we focus narrowly and try to make some faster incremental improvements or do we try to broaden the frame? Or, you could do some combination of the two, I guess. You could do some staging of them. So that's a topic on which I'd like to hear people make comments.

So let's see hands for round one, clarifying questions.

DR. BORMAN: I'd just like to explore a comment that was made about the multiple procedures reduction. I would agree with you that a good bit of the assumption in the background is the economies of scale on practice expense. There probably is some economy of scale on some of the physician work. I don't think it translates as evenly.

But I think I heard you say or imply that the reduction that's applied is applied only to the practice expense, and I think it pretty much comes down to a 50 percent reduction. It's not that you're maintaining my work and then only cutting by half, I do believe.

So help me to understand what I misunderstood.

MR. WINTER: My understanding was the entire payment for the second procedure is reduced by 50 percent. According to GAO's report, they found that that was to account for efficiencies in the practice expense portion only, but I'm not sure.

DR. BORMAN: If I could just share why I have a little concern about that, let me just give you an example from my own world. Let's say I have a patient with hemolytic anemia, destroys red blood cells, they develop gallstones and they need their spleen out. Okay?

I can do those two operations at the same time. Yes, I open the abdomen once. I close the abdomen once. So there is an economy of scale in my work.

But the considerations that I have to think about, about complications relative to the gall bladder part and the spleen part, are additive. They are not synergistic or

economies of scale. So I think that we have to be a little bit careful about the assumptions.

I would just say let's be clear. It's been reduced by half. You would get some potential disagreement that it all relates to the practice expense, saving, or mostly.

DR. STUART: Glenn asked a broad question about whether how important we think this is and whether it should be narrowly or broadly focused. I think it should be broadly focused, and I think it's an extraordinarily important set of questions.

And, I'll just ask a question that gives you some idea of another way that this might go, and that is you give us enough information here to question the way in which the two pieces are put together. The malpractice isn't very big, so you don't spend time on it. But it's all based upon certain information that comes directly from the providers themselves. My question is, well, how is this handled in the private sector?

In other words, you've got services that are over-valued and under-valued. How do they figure it out, and, if they do figure it out, is that something that we would want

to consider as a way to at least identify outliers within the system?

So you've got the system you'd still have to fix, the basic approach, but if it's really an outlier problem, then there may be a simpler way to identify these things.

MR. HACKBARTH: Your question, Bruce, was how do private payers set their relative values?

DR. STUART: [off microphone] Yes.

MR. HACKBARTH: I don't know if anybody has definitive data to offer on that

Kevin?

DR. HAYES: The AMA surveys private payers periodically, and, if memory serves, the last time they did so was in 2006. That was an update of a series of surveys that they conducted, and they asked questions about use of the RBRVS, of Medicare's relative values.

The finding, and here again I'm just going on memory, is that about I think it was close to 70 percent of -- now what is it? Is it payers or is it dollars? What? But let's say it's payers use the relative values.

There is some differences in terms of what they do with the conversion factor, as we know from our data that

the conversion factor, that something is lower. So we'd have to figure on the Medicare side. So we'd have to figure that, on average, private payers' conversion factors are higher.

The other thing that comes out in that work is that the private payers' conversion factors, that they use multiple conversion factors, that they might have a higher conversion factor for some specialty services than they do for, say, evaluation and management services.

So there are a lot of similarities.

DR. STUART: I could be accused of not staying within the question boundaries, but since you posed it, about the level of importance of this large issue I think we at least want to throw out the kinds of questions that would lead the staff to develop an agenda around this.

MR. HACKBARTH: Bob, did you have something to add?

DR. BERENSON: Yes, the Center for Studying Health System Change -- and Paul Ginsburg can talk more specifically about this tomorrow as part of the site visit process -- asks all the health plans how they set hospital and physician payment rates. In this area, it's very clear

that they all look at the Medicare RBRVS schedule and then have to deal with market conditions to see how they can implement it, but that they are not in general using techniques that are other than RBRVS.

DR. CROSSON: Just let me add another point. In the salaried environment, it's not terribly different because, as Bob noted, the Medicare RBRVS drives a certain level of compensation. It drives the plans, often, to use the same level of compensation which sets the market salary for physicians. When you're an organization having to recruit and retain physicians, you're often dealing with at least a strong reflection of that payment system.

MR. HACKBARTH: Okay. I assume responsibility for maybe getting us beyond the boundaries of round one, by posing my broad question. So let me try to get us focused on round one, clarifying questions, and then we go to round two and address my broader issue.

DR. CASTELLANOS: Ariel, maybe you could help me clarify this. You quote the GAO report. It's my understanding that data have not been released and have not been available to look at.

MR. WINTER: They have not released the pairs of

codes they looked at and the ones for which they identified efficiencies, they've not, nor have they released the specific percent reductions that they assumed for each pair of codes. They said, generally, they were about 25 percent based on the imaging reduction.

DR. CASTELLANOS: That would be nice to look at that. When that comes available, I would like to look at it too.

The other clarifying question I have is I really appreciate the data on, I guess, it's Table 1 on Page 4 that was in the material you sent out. I'm just asking, do you think the RVU data, this was 2009 data, is going to change based on some of the proposed changes in the physician payment rule, specifically eliminating the consults, specifically the equipment utilization rate and some of the new practice expense stuff? Do you think that's going to have much of an effect on the RVUs?

DR. HAYES: It would. Well, let's back up here and, for the group, point out that when Ron mentioned consults, the proposal from CMS is to essentially declare consultation services non-covered, in which case then physicians would use existing billing codes for office

visits and other things, to submit claims for consults. And, CMS is proposing to implement this policy in a budget-neutral way, we could say, which means that they would increase payments for the office visits to account for the shift of volume toward those visits, but otherwise maintain spending at a current level.

So that, in turn then, could result in some increase in the work RVUs for office visits and could have some effect on these results. It's too early to tell whether CMS will go forward with that proposal. It's a highly controversial one.

But, otherwise, the other proposals in the proposed rule would not have an effect on these numbers. I'm thinking here in particular about the use of new survey data to determine practice expense RVUs. That's because this analysis is limited to the work RVUs. Okay?

DR. CASTELLANOS: Okay, thank you.

DR. CHERNEW: I have a question about I guess it was the slide on page 4, where you said the second bullet point on the slide on page 4 was previous reviews led to far more increases than decreases when you looked at the RUC.

I was under the impression that the RUC had to

have budget-neutral changes to RVUs. Am I wrong about that?

DR. HAYES: No, you are exactly right. But what that means is that if RVUs go up for some services, okay, which is what's represented by the yellow bars on this slide, then that means that budget-neutrality adjustment applies to everything, to everything else in the fee schedule including the services that experience some increase.

DR. CHERNEW: So, when you said the previous reviews led to far more increases than decreases, there's actually not a budgetary impact of that, but it's just --

DR. HAYES: A redistribution of dollars among services.

DR. CHERNEW: My second and sort of related question was you said that the correlation between time and work RVUs was about 0.9.

DR. HAYES: Yes.

DR. CHERNEW: But when I looked at your slide and when I looked at the table on page 4, the differences in the compensation per hour are very different. Is that because something is going on somehow in practice expense or liability?

In other words, if I thought that it was really perfectly correlated between time and work RVUs and that there was a given dollar per RVU, there's something I'm missing. So my question is what am I missing?

DR. HAYES: Well, it doesn't have anything to do with practice expense and PLI. These values shown in Table 1 on page 4 are just the work RVUs. All right?

DR. CHERNEW: I guess I'm so confused. I need like round zero which will have to be later.

DR. HAYES: Yes.

DR. CHERNEW: Because I don't understand how the time can be so correlated with the RVUs and the RVUs converted in a conversion factor, but then you don't get the same dollars per hour across the services.

MR. HACKBARTH: So there's a correlation between time and the overall work RVU. The analysis of compensation per hours says, okay, look at, we're trying to analyze the residual.

DR. HAYES: Exactly.

MR. HACKBARTH: And, our way of analyzing that residual, the piece that's intensity of effort, is to convert things into compensation per hour, implicit

compensation per hour. This is the implicit intensity measure.

DR. CROSSON: I had the same question. What you're doing is you're dividing by time. So it's intensity times time divided by time gives a relative intensity, which can be expressed as dollars per hour.

DR. CHERNEW: But the intensity has got to be a small amount if it's 90 percent correlated.

DR. STUART: [off microphone] No, it doesn't. It could be correlated.

In other words, if time and hourly compensation are correlated, or put it another way, if you ran the correlation between intensity and RVU, it's going to be more than 0.1 because my guess is that there's some positive correlation between intensity and time.

DR. HAYES: Yes, that's going to take some sorting out.

DR. BORMAN: First off, time is correlated with work RVU, very tightly, work RVU. And, work RVU is about 50 percent-ish, 45-ish percent of the total RVU. Okay, so that's one thing. The tight correlation to time, the tightest correlation to time is to physician work.

There is some correlation of time to practice expense because the work value is a multiplier in the practice expense formula, one of several multipliers, but it's still a multiplier. So time is a factor less tightly linked in practice expense.

If you want to go back to the original Hsiao stuff, the two things that work correlated with was time and the setting in which the service was delivered. So that's the reason that there's these emergency room, da-da-da, whatever, codes.

So one of the other things operating in the background is the setting in which the thing is delivered. So that's just how it relates.

DR. SCANLON: My interpretation of this table was that we can have this phenomenon and have this tight correlation because we're talking about the correlation involving about 5,000 data points, and this is 4 data points. The four data points represent a potential problem that we might want to address, but it's not the 5,000.

If you plotted the 5,000, you would see the correlation. There's a little noise here, and this is the noise you're seeing.

MR. HACKBARTH: Okay. What I'd like to do is set this aside for right now. We've got an issue of presentation, Kevin, and we need to figure out a different way to present the data.

George, did you have your hand up?

MR. GEORGE MILLER: I did, but my clarifying I believe was answered, but I want to make absolutely sure. That is these numbers on the same Table 4, this is budget-neutral, and everything we're talking about is budget-neutral, on this slide?

MR. HACKBARTH: The change in the RVUs, yes.

MR. GEORGE MILLER: Okay, completely. Okay, thank you.

DR. MILSTEIN: A question about slide 6, the last bullet, that's not a small deviation. My question, is politics aside, do we have, from a technical point of view, does CMS have a way of implementing a survey that would be more accurate?

In other words, is the technical barrier solved? I couldn't tell from your presentation. Is it something we could adopt or is it unknown whether a more accurate survey is more feasible?

DR. HAYES: There's a couple of ways to answer the question. One would be to ask whether there are other data sources available to CMS, conceivably, to develop time estimates like this, and this would be the kind of topic that we would want to pursue, if we were to do work on this topic.

I can tell you right now that contractors for CMS have looked at alternative data sources. They have looked. For example, for surgical procedures, they have looked at operating room logs. For evaluation and management services, they have looked at the National Ambulatory Medical Care Survey which includes some estimates of time.

Now these data sources, I'll hasten to say, are not perfect. There are some limitations that the researchers, that the contractors have noted in doing their work, that would have to be considered in any use of data like this. But there is a potential there, it would seem, for some alternatives.

The other part of the work that we would propose to do would be to just see what it would take to generate estimates some other way, other than what's done now, which is either to rely on the work that Professor Hsiao did in

the late eighties or the estimates that the RUC generates.

MR. KUHN: Arnie, just one other way you could go about this is that you're actually right in terms of the other data sources, but CMS could probably do a limited study with a contractor that would look at, say, five procedures per year that are representative of each specialty that's out there, and they could go to a subset of hospitals.

Take out teaching hospitals because I think those would be a bit of an outlier, but I think they could do a pretty good survey of community hospitals and other hospitals and look at this information and get back some pretty good data, that then you could look at analysis and make sure that it's fairly accurate. But I don't think it would take a lot of effort to get some real accuracy and get some real-time data in this space.

MR. HACKBARTH: So, take this example here, the colonoscopy, what's the source of those estimates?

DR. HAYES: The 30 minutes comes from -- for that particular code, I believe that that is one that has been reviewed by the RUC. So it would be a RUC number.

MR. HACKBARTH: That's what I thought. And, the

RUC gets the number by asking the specialty to submit data for their service?

DR. HAYES: In general, to survey members and to submit data.

DR. BERENSON: As a matter of personal privilege, this came from me in a letter to the editor for the Annals of Internal Medicine, based on an interaction we had after Bill Rich wrote a letter complaining that we had used this example. This actually was original Hsiao estimates. It had not been through the RUC process. It was one of the unusual ones that was still Hsiao. What is still in the RUC database and on CMS, if you go, would be 30 minutes of intraservice time, 71 minutes of total service, pre and post.

It just happened that a few months before this interaction we had, the New England Journal had published an article on the identification of polyps based on the number of minutes you spend during a colonoscopy. I don't know if you remember it. If you spend two minutes, you find two polyps. If you spend four minutes, you find four polyps. They had recorded for 7,000 or so consecutive colonoscopies the data, and so that's what the comparison was.

But that was purely opportunistic that we had had that article published.

And, I agree with Herb completely, that we could just contract with some hospitals or for Kaiser Permanente and get some real data in this area.

We also could do the same thing with multiple -- we could bring in a lot of surgeons and ask them how much time you save by doing two procedures or we could go measure this and actually find out what the savings are.

So I think the suggestion here is that we get real data rather than guess.

MR. HACKBARTH: Could you tell me what percentage of the time estimates are carryovers from the original Hsiao work versus new numbers produced by the RUC?

DR. HAYES: I can't give you that. I can find out, but I don't know.

MR. KUHN: I would just say on that I think, if I remember data from a year ago, I think it was around 80 percent had gone through the process, but the 20 percent that had not were extraordinarily low volume procedures out there.

MR. HACKBARTH: Okay, so clarifying questions.

DR. BERENSON: You say on slide 4 that the next five-year review of RVUs will begin this fall. Traditionally, the five-year review was of work, and I understood there was going to be a separate five-year review cycle for practice expenses. Is that being combined in some way or do you mean work here?

MR. WINTER: We don't know when they plan to do a five-year review of practice expenses. We've asked about this in our comment letters, and, based on my recollection, CMS has not opined in their proposed rules or final rules about when this five-year review of PE might be initiated.

DR. BERENSON: So this is a five-year review of work.

MR. WINTER: I think that's what, right.

DR. HAYES: The only qualifier I would put on that is that we do want to see what the notice looks like that comes out of CMS and what it is that they're asking for in terms of the content of this five-year review. It certainly will be work, and it's just a bit of a question about whether it might include practice expense or not. I don't know.

DR. CROSSON: Yes, Kevin, on slide number 7, we

talk about the calculation of physician work, the intensity piece. Those elements that go into the calculation -- mental effort, judgment, technical skill, physical effort, stress -- in the calculation, are those actually given a value and then somebody totes it up and comes up with a number? Are they weighted? Or, is it simply that someone or some group looks at all of those together and makes a subjective judgment which then becomes a number?

DR. HAYES: Yes. My observation is that it's more the latter, that it's a result of a deliberative process that the RUC goes through to consider survey responses on questions about these matters as well as the time, all of this, comparing to a reference service. So it's -- and then a lot of discussion amongst the RUC members.

MR. BUTLER: Quick question, back to slide 6, we seem to be hung up on colonoscopies here, but just a scope question.

[Laughter.]

MR. BUTLER: There are situations where you got a code for just the professional component because there is no practice expense for the physician, and then in other cases you might be in a free-standing place where you would -- you

know. The practice expense would include obviously a lot more. Both of those are within the scope, again, of what we would be looking at, is that right?

DR. HAYES: These time estimates are for the time that the physician spends furnishing the service. So the practice expense, the time, say, that a nurse or others assisting in the procedure would put into the service, that would not be included in this.

And, it would be pretty much independent of the setting. I mean the physician is going to furnish the service in whatever setting, and it's how much time does the physician take in furnishing the service.

MR. BUTLER: Okay. But as you reprice not just the physician time component of this, but the technical component of providing a colonoscopy, how does that fit into this equation? Not at all?

DR. HAYES: That would be among the practice expense, the payment for practice expense. So, when Ariel talked about estimates and data used there, it could be that there would be some opportunity to look at the technical component as well.

MR. BUTLER: Okay.

MR. WINTER: The practice expense varies by setting, so it's higher in the office than ASC, OPD.

MR. BUTLER: No kidding, yes. That's the point.

MR. WINTER: But the work stays the same, as Kevin was saying.

MR. BUTLER: Right.

DR. DEAN: I just didn't understand on slide 8, for instance, to pick on colonoscopy again, the compensation per hour because $106 is certainly dramatically different than my understanding of what the real income per hour actually is. How did this get, this 106, get calculated?

DR. HAYES: This would be the work RVU for the service divided by the amount of time, stated in hours, that it's estimated it takes to do this service and then that multiplied by the fee schedule conversion factor. Now this estimate, this number could change if the time figure changes.

DR. DEAN: The other aspect of that, and as I recall the paper that Bob just referred to, is there was a variation in terms of the amount of time between different providers. Wasn't that?

DR. BERENSON: The variation was in minutes, a few

minutes. In other words, the difference between spending eight minutes or twelve minutes was the difference in the finding of polyps. This was a single group practice in any case, so it wasn't huge.

DR. DEAN: Okay. Maybe I misunderstood, but there was a correlation with the accuracy of the findings with the time -- the shorter the time, the less accurate the findings.

Anyway, I guess my question was how do we factor in the variability in terms of the speed at which physicians work? Maybe this isn't the best example. We know that in some procedures there is quite a lot of variation.

DR. HAYES: The estimates that CMS is aiming for here is the typical, the typical time.

MR. HACKBARTH: Okay, we are at 4:30, which was our original scheduled time for ending this. I would like to go around one more time quickly.

As I said at the outset, of particular interest to me is sort of helping the staff figure out how to focus our next steps here. Do we want them to sort of take a narrower cut at this, focused at some of the particular issues raised here, or do we want to open up broader issues about how we

pay physicians?

DR. BORMAN: In trying to specifically speak to that, Glenn, I think I see real risk for us, the biggest risk for us as a Commission, in mixing apples and oranges. That is coming at some things in a very detailed way and trying to come at some things in a very broad way. In the end, we will create more harm probably by being in the middle of that than we would by picking one or the other.

I think if you go back to almost your very first slide that's got the rising graphs, it just begs the question once again of if we're really going to deal with this why are we not focusing on the areas of most rapid growth in dealing with that, number one.

A second cut at that, potentially, is high-volume services. I would point at, just as an example of that, if you change one minute of the time in 99213, the established office patient, you move more money in that than you do for almost the entire fee schedule for certain surgical specialties because just of the enormous number of established office visits. So the magnitude of the differences, even though they're small, for high-volume services can become equal to things that are big differences

for small-volume services.

So, having said that, I would just urge us to be very careful about how deeply or how down into the weeds of some of this that we get as a Commission. I think we can certainly raise some questions, but it will just take too much education of all of us about the ins and outs of this to make very specific things about the methodology, I think, of some parts of the fee schedule unless we've got a very specific goal of a particular tweak that we want to get to.

I think looking at the broad issues, like this graph, are probably more productive. If we wanted to pick one of the items that has been brought forward, perhaps it relates to how we look at multiple procedure reductions as one facet of the how do we bundle services issue. I would like to maybe see it go from sort of just that narrow how do we do multiple procedures reduction to an idea of how we bundle services commonly put together. I think that might be an appropriate way to come at this, consistent with some of our other stuff.

But I think getting down in some of these other weeds about whether the components of intensity, how are they measured, da-da-da, I just think that's taking us down

a multi-year project. If that's where we want to go, great.

DR. STUART: I think that another possible cut on this thing is to ask empirically where we think the problems are. If I heard Herb right, if it's a question of outliers that's really generating this, then that's something that CMS, with some reasonable small addition of resources, could handle. So maybe our job is as the traffic controller here.

I mean is there some mechanism by which we could prioritize the payment issues and then focus on those and then pass that off to CMS?

DR. CASTELLANOS: I'd like to try to keep it as narrow as possible, but I'd like to look into the bundling aspect. I think that's maybe something we want to go towards.

DR. CHERNEW: I think because the fee schedules for the broader things that we talked about are going to be based off from what we observe in payments now, and what we observe in payments now is going to be based on the fee schedule that we have now, I think it's worth it to have a narrow dive, not in a particular service, though. I don't want to say that this procedure, that procedure.

But in sort of the process of what's happening

overall, I think that the narrow level is important, and I think we should reserve the broader questions about physician payment to the discussions of broader payment in general, integration across all the bundling things. So I would rather -- I do think there's room for a chapter on getting the narrow parts right because I think the narrow parts and its expense are going to go into the estimates, that when we have to come up with the fees for the other things, we're going to have to figure out what it costs.

DR. MILSTEIN: My notion is to focus narrowly but emphasize a speed of correction because my notion is that the willingness of providers to embrace a more enlightened system of payment is going to partly depend on closing off what has been a very, extremely poorly managed aspect of physician reimbursement under the Medicare program -- which is, in turn going to, kind of like a serious infectious disease, spread in the ways that Jay described, into the private sector and even prepaid health. This is a serious outbreak. It's endemic. It's been going on for a long time.

If I had to pick based on the evidence we've seen so far, where to focus, it would be, understanding that

there are obviously many imperfections in this cost-based payment system, it would be on the time estimates. What we saw was something that's off by order of magnitude of 60 percent. The idea that it's been tolerated for so long is remarkable and instructive in and of itself.

I think narrow, get it fixed because, among other things, it will encourage a more friendly welcome for new payment systems based on value.

DR. KANE: First of all, I think one of Bill Hsiao's collaborators, Peter Brown, had sent me a study on the problem with time, and I think there is -- a lot of work has been done. So I'll try to find that, but I think there has been some investigation of that. It may just be that no one has taken it up for a while.

And, that comes back to what I thought when we last talked about this, which must have been my first year here or something. We talked a lot about the process by which mispriced services are identified, and the process itself was biased towards identifying underpriced procedures. And, I know we made a set of recommendations about trying to create a way to identify overpriced procedures, and I don't know whether they were ever

implemented or whether we need to restate them, that there needs to be a way.

Maybe tables like Table 1 here is one way to get started or take a look at the stuff on time that I know has been done and say maybe somebody needs to review these, what look like overpriced services. So I think our proper purview is really on the process by which mispricing is identified and making sure they get the over and the under, as well as the under. I don't know whatever happened to those.

Then I guess my other recollection, as I recall it was probably one of our most painful meetings, was talking about practice expense. It's very complicated. I actually did research on it for CMS a years ago. It's a horrible subject because there is no cost data. People are not exactly making it up but very close to making it up.

It would be interesting to sort of get a MedPAC staff review of the new cost data that's coming in and how it looks relative to what was there before. What are the big changes? How have the different cost categories changed? The relativeness of the cost among the specialties?

It would be useful to just sort of get an overview of whether we think this new cost data are any better than what I really used to think was just made-up data. I mean it got to be so esoteric -- a socioeconomic survey, just really esoteric.

So is this new data set better? Then, if so, what would we recommend about whether it should continue to be produced this way, or how should it be tweaked to be slightly better than that? I think those are the two levels that I think the Commission can get engaged in.

Anything down to the level of a specific code, we don't want to go there. Bill Hsiao spent $5 million, 5 years and involved hundreds of people. We can't do that.

MR. HACKBARTH: Kevin, do you want to address Nancy's question about what's happened with our recommendations on reforming the process?

DR. HAYES: Sure, and I'll be brief, and this will be something that we would want to flesh out later. But, in general, the CMS has chosen not to set up the expert panel that the Commission recommended. They have, however, in the most recent proposed rule on the fee schedule, they did solicit public comment on this idea, which was the first

that the Agency really had acknowledged the recommendation. So we'll just have to see now what they do.

They will, of course, get a lot of comments. We, in our comment letter, reiterated the recommendations that we made, of course. It will be good to see now in November if they will be put out a final rule that will have response to comments, summary of comments and a response to them. So we'll just have to see where that goes.

The other thing to say here is that, and I think this is fair to say, it's motivated a lot by what the Commission recommended in 2006, that CMS has worked more closely with the RUC on these issues. For example, last year, the Agency sent the RUC a list of over 100 high-growth, high-volume growth codes and said, please review these. There have been some other things like that, but that's the most visible example of an initiative that CMS has taken in this area.

The RUC itself has formed a work group to address, which has, in turn, -- to address potentially misvalued services and to do so in between five-year reviews. The work group has set up, has adopted a set of screening criteria. They apply it to data and have identified many

codes for review.

That process is still ongoing. It's kind of hard at this point to summarize what it is, but, in any case, there is some activity. But that key piece having to do with the panel that the Commission recommended, that has not happened.

DR. KANE: I'd like to hear all those things sort of put into the background here before we think about whether we want to, can or should or want to do more because it seems to me it was more the process was the issue, not the specific details. It would be nice to get caught up on that.

DR. BERENSON: Yes, I was just going to make the same point that Kevin just did. I think from my vantage point -- I work in this area -- MedPAC's recommendations in 2006 were very important in a number of ways. It got the RUC much more responsive and assertive in their responsibilities, and I think they have now dramatically improved what they are doing around mispriced services.

The recommendations have been part of House and Senate legislation, and we'll see what passes. But the Senate Finance, Mark, now has a multi-stakeholders sort of

committee that would play a major role in this area.

And, I can say that there are consumer groups and private payers and purchasers who look at how these fees have been calculated over the years and articulate great concern about the fox guarding the chicken coop and where are beneficiary interests represented.

I don't know that at this moment we would want to go into a new method of factoring value of services on our own because I think we have plenty to do just within the construct of getting underlying resource costs correct.

I think one of the common threads across the four, at least three of the four, issues you posed is whether there is a process approach for substituting real data for estimates, and that is true on practice expenses also. We have talked, as I understand it, MedPAC has talked about identifying efficient providers and figuring out what reimbursement should be for efficient providers. One could think of a sampling approach to identify a range of physician practices, but somehow defined as efficient, to get some real data on practice expenses rather than relying on a survey that may or may not happen, where again -- I mean I just think.

I don't have the answer at this moment, but I think we can constructively contribute to a discussion of how economically and efficiently we could start moving away from, frankly, self-interested estimates by specialty societies to objective data, and I think we should. That should be out top priority.

While I think some sorting out is going on about the role to which the basic construct of how these fees are conducted or determined, while that conversation happens, I don't think we should lead with that, but perhaps we'd come back to that in a year or two.

DR. CROSSON: So, if you could lay out the spectrum here of doing nothing versus taking on the whole spectrum that you talked about, it sounds like one choice would be to leave everything alone.

The next choice might be to simply work on the time element of the work RVU.

The next choice would be to work on time and intensity. I suppose you could work in intensity and not time, but there does seems to be a sense that the time piece is more easier to get at.

Another choice would be the work part and the

practice expense part, but there's some discussion about whether we want to take on all that.

And then, to go further than that, it would seem to me it would be the idea of why don't we forget about all of it and think about paying an efficient provider or think about how to factor in issues like societal value and the like.

So that's the spectrum.

I think where I come down is, if we can, to work on the work part of this and to look at both time and intensity because I think the time part is probably doable. It's something that's objective, can be measured. Corrections could be made, particularly to the areas that seem to be outliers.

The intensity part is much more difficult, but I have the sense, and I've been affected by Tom's description for sure. I have the sense that perhaps the relative intensity now -- for example, between a family practice physician taking care of 90-year-old patients with 5 conditions and 15 drugs and the work of some other physicians, the relative intensity difference may be different now in general than it was 30 years ago.

At least, we have marketplace that seems to be saying that in the sense that younger physicians are looking at the choices of careers and are saying, and I understand some of it is based on how much money they could make, but some are also saying it's just simply too hard. There's too much stress. There's too much mental effort. There's too much physical effect, of practicing general medicine. I'd like something which is simpler.

So the market is saying, perhaps, that those values which may have been set appropriately 30 years ago may not have been properly updated and, therefore, need to be looked at again.

DR. SCANLON: I'm in the narrow camp as well, but at the same time I think it's very important that we do something in this area. Part of being in the narrow camp, I mean, would be that I think that it doesn't take much, if you look at historically what's happened, to come up with a set of principles about what you think would be improvements in some respects, in the current system.

The first one, I'm kind of echoing what Bob said, is data. It's not acceptable that we don't invest in the collection of data. It's not acceptable that we don't

insist on people giving us data, that are participating in the program.

We talked about this the last cycle. The fact that we've got new practice expense data now is just happenstance because for about four years here we've been talking about how this survey was underway and the response rate was still low and we were trying to boost it.

In 2013, the group that's here shouldn't be talking about the same thing, about practice expenses. It's going to potentially be updated next year. So that's sort of one thing I think.

I mean in terms of time and intensity, time is the easy thing to think about in terms of data, if you make the investment.

Intensity, I'm disturbed by what's in Table 8. I don't understand it, and I think I believe that there's an intensity. There's a need for an intensity adjustment, okay, but I don't know how to get there. So I think taking that on, I don't know where we end up because that's a difficult conceptual question.

Frankly, as an economist, I would have thought about sort of building fees in terms of what was your

lifetime return to your investment in your education, and you think about that. It's in terms of, okay, I've got different levels or different amounts of time spent in education, which involves different amounts of debt, expense, et cetera. Then I have different career patterns, career life, in terms of how long can I practice doing this kind of thing before sort of I am going to be outmoded. So that, to me, was something as a way of thinking about what the costs are in terms of attracting people to particular specialties.

I know we're not there. We're dealing with intensity, which I don't understand, but I think we have to.

MS. HANSEN: My question is probably just a different angle on the issue of time and intensity, and that is access, taking it from an access standpoint.

I've talked to my son who is an orthopedic resident, and we talked about some of the patients that you have. So it's somewhat the Jay example but somewhat different. Say, you have somebody who is a 300-pound person who's having some orthopedic surgery as compared to a colleague of mine who broke his hip, whose 45 years old and a bicycle rider.

So the complexity of dealing with this, some of it might be age, but some of it might be an older woman who is extremely osteoporotic and having a problem as compared to, again, somebody who's younger, who's getting a knee replacement. How do you weight for that, so that ultimately the practicing physician is compensated appropriately, however this appropriateness is, using time and intensity and accuracy, so that they do not shun these kinds of patients, the more complex ones?

So I don't know what that is, but I'm concerned from the access standpoint.

MR. BUTLER: So my view is not a continuum; it's an either/or.

On the either side, I would say that Congress is our customer. We have a five-year cycle that we have upon us. If we have a unique insight or an independent voice that is going to make a difference in this five-year cycle, that's where we should focus our energy, if that's on the time side, whatever. So it's either a technical insight or an independent voice that will contribute.

If there are 50 voices out there and technical expertise and we're just another voice, I'd say abandon that

and go to the blue sky. The physician-centric, office-based visit view of the world in the way health care is going to be delivered in the future is going to be outdated, and we should think about different ways if we're going to interact between patients and systems and so forth and focus totally at the other end, exclusive of this issue.

MR. KUHN: As we look at this, and I too think we need to think narrow here, but as we think on a go-forward basis to new payment models that ultimately, hopefully, will pay for efficient providers, if we don't have this platform as accurate as we possibly can and we have this once, we have this chance in this five-year review, because whatever we go forward with will likely use this as a base to build upon. So I think this is time well spent, and it's worth doing.

Having said that, there's about four areas I'd just like to comment on real quickly.

First is the multiple procedures, and I like the notion of commingling, also bundling with this. I think this would be very valuable work for us to do. I think, as we all know, there are many physicians who code in a very micro way, and I think there is a pretty good school of

thought out there is that when you have that kind of detailed coding, it does lead to inflated RVUs. So I think our chance to kind of work in this area would be valuable and useful.

In terms of the practice expense and up-to-date, I have a little pride of authorship in this study. So I know you didn't mean to call my baby ugly, but I'm the one that did sign the contract at CMS for this particular survey. So I hope it comes out good, and you get all the information you want.

But, as we go forward on this survey, I think some recommendations from MedPAC in terms of how to keep this information to date because we'll finally get some baseline information that's been long overdue. Whether it's the American Medical Association that's doing the survey, whether it's an opportunity for CMS to contract with them in the future or whether there's some kind of third party entity, some foundation or some other research group that can do that, where there's some trust.

But it can't be CMS because the physicians just won't trust CMS. CMS tried to this survey in the nineties, and it just didn't work.

The accuracy of the time data, we already talked about that a little bit. I think there is a pretty easy way for CMS to contract and move in this area.

Then finally, on the work estimates, and I think it's worth for us to kind of recycle the recommendations that you made before. I will tell you, when I was at the Agency, the recommendations MedPAC made were extraordinarily impactful on CMS in terms of the actions they took.

Yes, we didn't take action in terms of the panel that we thought about, that you all recommended. That would have been basically some managed care docs and VA docs and medical officers from CMS and others, but it was a federal panel. Would the physician community really trust the work of a federal panel in this and could they replicate the work of the RUC?

I think our thinking at the time was it probably could not. At least that was CMS's view of the world in that regard, and just we were worried about the credibility of that.

But, instead, what we thought we would do is start this effort, and you talked about it, of the 100 procedures and send those into the RUC, work with the RUC and start

that process.

So I think one of the things, we might want to think about refining some of our recommendations. Is there a chance that we could help CMS think about data-mining exercises that they could go through and pick out either other procedures or the time lag from the last time the RUC looked at those procedures or a variety of different things, but give them the guidance because they're already kind of in for diamond, for dollar.

They've already sent the 100 procedures. If we could give them an algorithm that helped them look, that they could pick even more procedures that we thought make sense, it might work as well as one of our recommendations. It's something to think about.

MS. BEHROOZI: I would vote for taking the broader look and talking about some of the broader issues that we talk about over the course of our various different discussions.

And, going back to the concept of value, it really does seem like there are a lot of value judgments sort of embedded, particularly in the intensity measurement. The way you described them in the paper, clearly, they are

supposed to be from the physician's point of view, but they also really reflect our value judgments about what we think is the most important thing that physicians do or the hardest thing that they do.

I think that in all our other discussions we talk about the value to the patient and the value to the purchaser. Medicare is a purchaser. I think those don't always correspond to looking at it from the how hard is it for the physician to do this thing because, going back to the example of Tom and his patient, yes, that sounds a lot harder to me than a lot of the other things that seem to be the real hoity-toity things by this list or whether it's diagnosis of pain, that the person can't even tell you where it is. There are a lot of things that I think we need to express our value through dollars.

But that's a big thing, and that's difficult, and we can't just leave this alone, the mess that it is I think, until we get to that more perfect system for paying doctors.

So I think some of the points that were first raised by Karen and I think others have said similar things, to really focus on mispriced services or the areas where we really can have the most impact by looking at the specific

components, but not across the board, not for everyone.

DR. DEAN: I think obviously we need to try to make this as accurate as possible. Having said that, I think the basic system is fundamentally flawed and because primarily for the reason you raised, Glenn, that it doesn't include the value. There's nothing in the system that tells us whether that procedure should have been done in the first place, let alone whether it's well done or not.

The other thing, measuring intensity is extremely difficult. You can take all the demographic factors you want, and it still doesn't describe the difference. I mean you can have two people with exactly the same factors, and there will be a massive difference in how the struggle that we go through in trying to set up a plan of care.

And, the other thing is it's a constantly changing environment, especially with the technical procedures, that things that are -- I remember hearing stories of the early days of cardiac surgery, when the surgeons really struggled because they were in an ill-defined zone. Now much of that is pretty well -- I don't mean to say it's easy, and I don't want to give the wrong impression, but still it's very different than it was in the fifties and sixties.

There's a great deal of difference in the way physicians approach things. Some take much longer to do things than others. So it's just I think we're trying to do something that just inherently may not be possible to do.

I mean I like Nancy's suggestion. We need to focus on the procedures which seem to be out of line, and we need to emphasize the fact that we probably need to be looking for better ways to do this. But, given what we've got, we should try to do the best we can with what we've got.

MR. HACKBARTH: Okay, so the bad news is that we're a half hour behind, and it's 5:00. The good news was that even at 5:00 people seemed to think the topic was important that they were still engaged in the conversation.

The bad news is that we've got another hour to go, and I suspect that this is also a topic that's going to engage people. So the likelihood that we're going to make up this half hour in the next half hour is not very good. So we're going to be running a little over time tonight.

Thank you, Kevin and Ariel.

And, Ariel is back again for more.

MR. WINTER: Hello again, slightly different topic

but still on the physician theme.

Over the last several years, the Commission has expressed concern about the volume growth of physician services and its impact on Medicare's fiscal sustainability. In addition, several commissioners have raised concerns about physician self-referral, involving specialty facilities and in-office ancillary services. The physician self-referral law, also known as the Stark Law regulates these ownership arrangements.

In today's session, we will examine a provision in the self-referral law that allows to physicians to perform ancillary services and other kinds of services in their offices. The question we'd like you to consider at the end is whether we should pursue further work in this area.

So, here, we define the self-referral law. The law prohibits physicians from referring Medicare or Medicaid patients for certain designated health services to a provider with which the physician has a financial relationship, unless that relationship fits within an exception. Designated health services include clinical lab tests, imaging, physical therapy, radiation therapy, hospital services and other services, a few other services.

The law generally prohibits physician ownership, but physicians are allowed to provide most designated health services in their offices under the in-office ancillary exception.

The law also applies to compensation arrangements between physicians and facilities, but we won't be focusing on that today.

According to a summary of the original Stark Bill, the rationale for the exception is that there's often a need for quick turnaround time on diagnostic tests such as lab tests and x-rays. However, Congress ultimately included most other designated health services in the exception, such as radiation therapy and physical therapy, even though some of these are not diagnostic tests.

The services that Congress excluded from the exception were most types of DME and parenteral and enteral nutrition services.

The exception has three key requirements which are listed here:

First, the services must be personally furnished or supervised by the referring physician or another physician in the group.

Second, the services must be furnished in the same building where the referring physician provides other physician services or in a centralized location that the group uses to provide designated health services.

And, three, the services must be billed by the physician or the group.

Here, we looked at some of the potential benefits and concerns that have been raised about physicians providing these kinds of services in their offices. Supporters say that there is improved access and convenience for patients. According to one study, patients are more likely to receive a test on the same day as their office visit if they are seeing a self-referring physician. In addition, physicians with in-office equipment may be able to get test results faster, which helps with continuity of care and developing a treatment plan.

However, additional capacity for services like imaging could lead to higher volume, and there's evidence that more CT and MRI machines in a market is associated with higher overall volume.

In addition, physicians who invest in ancillary services for their offices have a financial incentive to

order additional tests and treatments. Indeed, several studies support this hypothesis, and it is unclear whether the additional services meet standards of appropriateness or contribute to improved patient outcomes.

The in-office exception has had a major impact on how physician practices are organized and how and where services are delivered. Over the last several years, there's been an increase in imaging, pathology tests and physical therapy in physician offices.

In the proposed rule for the 2008 Physician Fee Schedule, CMS noted this phenomenon and asked for a comment on whether certain services should no longer qualify for the exception, such as services that are not needed at the time of the visit to help with the diagnosis or treatment. CMS has not yet followed up with a specific proposal.

The Commission has also examined various aspects of the Physician Self-Referral Rules and recommended ways to strengthen them, but we have not delved into the in-office exception.

In response to CMS's request for comment, as well as commissioners' interest in this topic, we could explore possibilities for modifying the exception. In a few

moments, I'll mention some of these ideas, and I want to mention that we're going to use diagnostic imaging as an example to illustrate these ideas, but they could be applied to other services that are covered by the in-office exception as well.

First, I just want to briefly explain why we've chosen to use imaging to illustrate these ideas. They've experienced rapid growth over the last several years, along with an increase in physician investment in imaging equipment. Of course, there are multiple factors that, besides driving growth, besides self-referral, include technological advances, defensive medicine and patient demand, among others. Further, a large body of research, including an analysis conducted by the Commission this past year, has found that physicians who own imaging equipment are more likely to order imaging studies.

These patterns are not unique to imaging. Several other kinds of services covered by the exception have also been increasing rapidly, such as physical therapy, radiation therapy and lab tests. There have also been reports of increased investment in these services by physicians, by the physicians who order them.

So, here are some ideas that we want to put out for your discussion, and these are simply concepts to frame possible directions that could be pursued and are not meant to be concrete proposals.

So the first idea listed here is to exclude all imaging services from the in-office exception. This would be a fairly simple approach to implement, but it would be difficult to justify because some types of imaging are used to make rapid diagnoses in the office, just taking a chest x-ray to diagnose pneumonia, for example.

The second idea would be to exclude imaging services that are not generally performed on the same day as an E&M office visit. The rationale for this approach is that certain imaging services provided in physician offices go beyond what is necessary for the physician to make a rapid diagnosis at the time of the physician's visit, which has been cited as a justification for the exception.

One article was found that the rate of same-day imaging tended to be higher for certain modalities, such as standard x-rays, than for others.

In addition, certain studies may require advanced patient preparation and therefore may require advanced

scheduling. For example, a patient who receives a CT with contrast dye may have to fast for several hours beforehand.

However, it may be difficult to set a standard that distinguishes imaging tests provided on the same day as a visit from tests provided on different days. This is because the rates of same-day imaging for a given test may vary by type of practice, clinical condition, geography and other factors.

The third idea is to exclude practices from performing imaging under the exception unless they are paid on a capitated basis, but surrounding this approach is a concern that practices have an incentive to order more services when they are paid on a fee-for-service basis. In contrast, practices that receive a fixed amount of money per member per month do not benefit financially when they order additional imaging studies, and, in fact, they have an incentive to use resources efficiently.

A recent study found that practices with a higher proportion of revenue derived from capitation were less likely to provide imaging studies to patients with uncomplicated low back pain, which is a condition for which imaging is rarely indicated. This suggests that capitated

practices may be less likely to use imaging inappropriately.

However, a study of Group Health Cooperative, which is a largely capitated health system, found that the use of imaging for its members grew rapidly over a 10-year period, and this suggests that the incentives in a capitated system may not be sufficient to restrain volume growth.

This approach would also raise some implementation questions. The practices need to be fully capitated or partially capitated to qualify for the exception. You would probably want to allow practices that see at least some fee-for-service patients to qualify, but if you set the threshold too low, then you haven't really changed the incentives.

Another question is how CMS would determine if practices are complying with this rule. One option would be to require that practices determine for themselves whether they meet the standard, based on criteria established by the Secretary, and this is how the in-office exception is currently enforced. Another option would be require that practices submit information on their revenue sources to CMS, which would then determine if they meet the standard for capitation.

Finally, I want to reiterate that although imaging has been used as an example here, the concepts could be applied to other in-office services.

I want to move on to some key objections that could be raised regarding any approach to limit the in-office exception.

First, it would require some patients to go to other providers for ancillary services, which, it could be argued, could lead to access problems, patient inconvenience, fragmentation of care and lower patient compliance. However, the hypothesis that patients who obtain ancillary services in physician services receive higher quality care or better outcomes has not been rigorously tested.

Second, many physicians have invested in equipment, staff and infrastructure to provide ancillary services, and they could argue that new restrictions on their ability to offer these services is unfair.

And, third, there could be a perception that limiting the types of ancillary services physicians can provide in their offices would interfere with the practice of medicine.

Next, I want to briefly mention some other approaches that have been or could be pursued to address concerns about physician ownership and volume growth. You could think about strengthening quality standards for providers, improving payment accuracy in the physician fee schedule and other payment systems, measuring and reporting on physician resource use, combining services that are furnished during the same encounter or episode of care into a single payment which Kevin and I talked about earlier, or efforts to encourage greater use of clinical guidelines and appropriateness criteria by physicians. The Commission has already done a lot of work in the first three areas.

So, to sum things up, the Commission has expressed concern about the volume growth of physician services. In addition, several commissioners have raised concerns about physician self-referral. An important provision on the self-referral law regulates the ability of physicians to provide many services in their offices, and we mentioned some ideas for modifying this exception.

We'd like to get feedback on whether we should do further research in this area or whether you'd like us to pursue other steps to address volume growth.

MR. HACKBARTH: Thank you, Ariel.

Could I just start with a clarifying question about page 4?

So, under the concerns, the concerns have to do with increased volume and appropriateness. Isn't one of the concerns also that it potentially skews the clinical decisionmaking? Ron has mentioned the example of radiation therapy and all of the patients is getting radiation therapy have cancer. So it's not like an imaging test that's totally unnecessary or of very marginal value.

But the issue might be is the cancer patient -- is the choice of therapy for the cancer patient skewed by the physician's ownership of one particular way to treat the problem? I think I would add that to the list of concerns about the way things work now.

So let me see hands for clarifying questions, and we'll start over here, Peter, first.

MR. BUTLER: I realize we're talking about all in-office exemptions, but we're using imaging as an example here. So remind me a little bit. We also put imaging at the highest growth of any. Could you separate that a little bit between the larger imaging CT/MRI which may be in an

orthopedic big practice versus a kind of bone density x-ray sitting in an internist's office, the smaller ticket items in terms of where the growth has occurred.

MR. WINTER: So, in general, there's been much more rapid growth in advanced imaging, including CT, MRI and PET, than in standard imaging and ultrasound.

MR. BERTKO: Ariel, I'm confused on how the capitation alternative would work in fee-for-service medicine. Are you saying that members would need to choose their radiologist or something and then get a capitated payment there, or is it just not going to work?

MR. WINTER: What we're suggesting is that to be eligible for the exception the practice would have to be capitated. Then, that is in order to be able to offer imaging studies or other designated health services in their offices, they would have to have a certain level of capitation, probably not 100 percent because you want to allow them to see some fee-for-service Medicare patients.

So it affects the practice itself, and then the patient would decide, choose a practice, and that could be one of the factors in their choice, but it wouldn't be a patient-level rule; it would be a practice-level rule.

MR. BERTKO: Okay. So I'm still confused, if this would mean that the practice was under a capitation contract with an MA plan, and then you assume the spillover would help control their usage in a fee-for-service environment. Is that it?

MR. WINTER: There are different ways to think about it. The rule could be based on all of their patients and all of their revenue or Medicare. So you'd be, in that case, Medicare, MA fee-for service.

DR. MARK MILLER: That is the concept.

MR. BERTKO: Okay, and you pick some threshold of capitated percentage. Okay.

MR. HACKBARTH: So, in essence, it would be on slide 3, you have the 3 key roles, and so the idea is there would be a fourth role, that the practice has to have a certain percentage of prepayment.

Clarifying questions?

DR. MILSTEIN: Ariel, has there been any studies that sort of examine? For me, this is a little bit analogous to coding creep. Right? I mean if you own it, you start to use it more as compared to before when you didn't own it or compared to your peers practicing the same

specialty that don't own.

Is there any attempt to kind of just quantify what, let's call it -- I don't know -- creep, let's call it for want of a better term, what that is by different types of self-owned, in-office owned ancillaries because, if so, then you could sort of intuit that you might be able to come up with something analogous to what CMS does in many other programs when there's creep. That is an induction inadvertently of behavior you don't want to encourage, but the reason it's induced is for good reasons.

It's Ron's point about it's more convenient for patients. It's maybe more efficient for doctors. So there are reasons why we might want to not eliminate the exception.

I mean this is too long a question. Let me focus it. Do we have information for these different in-office ancillary exceptions on the percentage by which volume tends to increase if you own it compared to if you don't own it?

MR. WINTER: Right. Most of the studies that have looked at this issue compared physicians who own it to physicians who don't, on imaging on lab tests or other main diagnostic tests that have examined, and they find a higher

use for physicians who own versus those who don't. There are questions about unmeasured severity.

So one study that we're aware of that was presented by Laurence Baker at the September, 2008 meeting did look at pre/post -- so what happens to practices if you compare their patterns of ordering of MRI before and after they acquired MRI equipment -- and found there was a significant increase. I don't recall the magnitude, and I can get that information to you.

We're also planning to do that kind of work ourselves with the database we constructed for the descriptive work that we presented to you last April and published in the June report.

DR. MILSTEIN: One more question, did you consider creep adjustment one of the options?

MR. WINTER: Could you flesh out a little bit what you mean by creep adjustment?

DR. MILSTEIN: Well, what you just described. Let's take the Laurence Baker kind of data. So you know that if you do a before and after comparison for different types of in-office ancillaries on a specialty match basis, there tends to be a certain volume surge. Let's call that

percentage increase, the creep.

Did you consider that as one of the policy options, that simply if a physician owned it there would be a payment adjustment to reflect what's known about the induced demand levels associated with owning it versus, in the same specialty, not owning it?

MR. WINTER: We can add that to the list to think about.

MR. GEORGE MILLER: Thank you. One technical question that I have, if we've measured the financial impact to the entire program on this business you've identified, where a physician or group of physicians had purchased equipment or lab equipment and used it, could you give me a global figure or do you have an idea what the global figure, the impact this could be?

MR. WINTER: Difficult to quantify. You'd have to make some assumption about the induced demand effect that Arnie was talking about. Once you have that, you then have to examine, okay, what percent of practices have invested in this equipment and are ordering that.

We've done that to a limited extent with the data set we have of the beneficiaries from the six market areas,

for imaging alone. But to do that for the whole program, across all the different services covered, would be a pretty big analysis.

MR. GEORGE MILLER: But this is a significant amount of money, you think?

MR. WINTER: I think for imaging, based on what we saw from the analysis we did last year, there's a fair amount of money here, if you look at the differentials and the proportion of physician ownership in those market. But I'm speaking from recollection here. I want to go back and look at the data.

MR. GEORGE MILLER: Thank you.

DR. CASTELLANOS: Carrying on with the example you use on imaging, you know the Commission has made significant recommendations. The data that you provide are up to 2007. The DRA kind of kicked in on 2007, and the data are available now.

Is there any way we could show that data, to see what effect we've had by some of the recommendations we've already made?

MR. WINTER: So the DRA went into effect on

January 1st, 2007, and our data go through the end of 2007. So we do see, in terms of some imaging studies, the volume started to level off, particularly for nuclear medicine, for example, and MRI. For other kinds of imaging that were affected by the DRA caps, CT mainly, the volume has continued to increase at a pretty rapid clip.

GAO looked at, examined the same question or examined this question directly. We have not examined it directly. GAO examined it directly, and they found that the volume in terms of numbers of services for the codes that were affected by the DRA cap grew almost 4 times as fast as codes that were not affected by the cap during 2007. So, in their view, access was not compromised by the effect of the DRA cap.

But, again, that was not our recommendation. I think you asked me about the effects of our recommendation. Are you referring to the equipment utilization assumption?

DR. CASTELLANOS: I'm referring to the data as of 2007. There are a lot of things that have happened since then, and I wonder if we could get any data on what occurred since 2007.

MR. WINTER: Right. So, for the data inclusive of

2008, we'll be examining for the physician fee schedule update. I'm looking to Kevin to confirm that, and he's nodding. So we'll be bringing that forward in future meetings.

MR. HACKBARTH: Let me just follow up because I had a question similar to Ron's. So, in DRA, we have sort of an experiment, if you will, on the power of price change, on the spread of a particular type of equipment.

The first and most easily seen effect in our data would be changes in the growth rates of particular services, but a more powerful or a different type of indicator of whether this is having a big effect would be how many physicians have changed their minds about buying high-end imaging equipment as a result of this change in the price. Is there any way to get at that?

So the slowing of the growth rate may conceal somewhat the power of the tool. Does that make sense?

DR. BERENSON: We could certainly look at difference in place of service, which would be -- although the practices that had invested would probably have to uninvest.

There is anecdotal information on that which

suggests that there was a dramatic reduction, but that's anecdotal, a reduction in purchasing by practices that had been going on.

But, in any analysis, I think you would certainly want to look at place of service and see if there's a shift. Right?

MR. WINTER: I think you'd want to look at the number or proportion of practices that acquired equipment in each year and sort of look at how that's changed over the last couple of years.

DR. BERENSON: But just in claims data, I'm saying, which is look at the impact of, say, the DRA reductions in imaging where, in aggregate, the volume is still going up, less than it had been going up. You want to know where it's taking place.

MR. WINTER: I think, just to finish my thought there about looking at the number of practices investing, sort of new entrants to the market, let's say. It's a little bit difficult because a practice might have -- a number of practices might be -- there might be fewer practices in aggregate numbers, but they might be bigger practices because they might be combined and consolidating

in order to get the capital to purchase the equipment. So it's a bit hard to say, to interpret those results, but it's something we can think about.

DR. CASTELLANOS: Just a clarification, I think I've seen some data showing that the site of service, that it is beginning to change and going back out of the doctor's office into the hospital or into a radiation facility, x-ray facility.

DR. BORMAN: Ariel, on slide number 9, when you talk about strengthening the quality standards, is your idea there that that's primarily judged by some safety metric? Is it going to be by some sort of accuracy metric?

I'm a little unclear here what that might look like, just sort of as you start to think about it, because from my personal standpoint I think both those things would be important, that it's done properly, but also that the quality in terms of is this a test that then has to be repeated by somebody else because it didn't answer the question. That would be helpful, but I would not want to necessary base it on things like necessarily provider specialty or something like that.

Did you have thoughts about what quality standards

would be?

MR. WINTER: I was thinking here primarily of the recommendations we made on quality for imaging standards -- I'm sorry, quality standards for imaging providers, which were not meant to be distinguished among specialties. They weren't meant to say, radiologists can do it but not cardiologists. However, they were designed to have a sort of baseline standards that would apply to the quality of the equipment, the qualifications of the technicians, the accuracy of the images that were produced and those sorts of things, as well as the qualifications of the interpreting physician.

So, thinking more in terms of accuracy as you've defined it and sort of baseline quality rather than distinguishing among specialties, but, again, this is something you guys could talk about, whether you want to go in a different direction or apply this to other kinds of services.

DR. BORMAN: Then, if I could just ask, the creep adjustment that Arnie brought up -- and maybe Herb can help me here and you from your HCFA days -- sounds a lot to me like a behavioral offset.

Currently, there is a behavioral offset in the fee schedule just about every year that sort of comes from some -- and I don't mean to offend, but -- kind of magic that I don't exactly understand. But it sort of pretty much applies across everyone because it does come typically at the conversion factor level.

So I think that what Arnie is suggesting, unless I've misunderstood it, is in fact a targeted behavioral offset. Am I understanding that correctly?

MR. HACKBARTH: Frankly, I'm not sure what you're saying. In estimating the budgetary impact of changes in the physician fee structure, the CMS actuaries do what they refer to as a behavioral offset, the general idea being that if you constrain fees or reduce it for a particular service, that might evoke the response of more of it to try to make up for the lost income.

But, in terms of how the fees are set overall, I don't know of -- there's a budget neutrality adjustment, as we discussed earlier, in terms of recalibration of RVUs. I don't know of any other behavioral offset that's done.

DR. MARK MILLER: That's exactly what I would have said, and I read Arnie's point as saying if you have two

physicians who are exactly the same, assume for the moment, except that one owns the machine and one doesn't, make literally adjustment in the payment rate, that reflects the fact that there is some implied or some induced utilization there.

But your run-through on the general induced utilizations -- generally, when you're scoring legislation and you change the fee overall, it's a factor that goes into the estimate. Some of the savings are lost because volume takes some of it back.

DR. MILSTEIN: This would be kind of analogous to making an equivalent adjustment for the in-office exception but doing it retroactively now that we realize that induced demand is a problem. In other words, it's analogous to that.

You're essentially saying, well, long ago, we allowed this in-office exception, and we know based on research such as Laurence Baker's that if you took a pre/post of the exact same physician's practice, pre/post, and compared to the rate of change of peers who don't own it, there's an induced demand.

We should have done it, to be perfectly parallel

to what's done in other aspects of policy. We didn't. We failed in this case to anticipate a dynamic effect. Now that researchers like Laurence Baker measured it for us, why not make such an adjustment retroactively?

DR. BORMAN: Then the last clarifying piece, if you go to, I think back toward your first slide, but it kind of almost doesn't matter, in the sense of I just reiterate that volume matters, not just the price, the unit service price.

Again, you have the two leading curves -- lab and imaging. They're somewhat different in the sense that the imaging has a high unit price whereas the lab has a high volume use. So I think, unless I've grossly misinterpreted, we need to be sensitive to that difference in the drivers if we're going to target or craft actions based on those, if that seems reasonable.

MR. HACKBARTH: Round two, comments.

MR. KUHN: Thanks. I think there's two areas that I think it would be useful for the Commission to look at, at least probe a little bit more.

The first has to do a little bit with the exception that deals with therapeutic versus diagnostic. I

think diagnostic is pretty clear, that this is an area that makes sense, but I'd like us to probe a little bit on the therapeutic side only from the aspect that there is anecdotal information. I think CMS received comments on this when they put this notion out in their rule a couple years ago, that Ariel talked about.

Is there an inducement there for the physician just to refer to the service they have in their office, where there might be other treatment modalities available, but there just is an incentive to go to the one that they have in their office? I'd really like us to look at that differentiation between therapeutic and diagnostic and see if there are any problems there that we ought to opine on.

The second area I think it's worth for us to look at is the time-based rationale. You know the purpose for this exception was the convenience. But say that someone is in seeing their physician and the physician says: Okay, I think you need an MRI. Go across the hall to see my assistant.

You go across the hall, and they say, I'll schedule you for next week.

I mean that really kind of takes away the notion

of a convenience. I think the idea when this was put together was the same-day service. I mean that was the idea here. So, if we're seeing a lot of things scheduled outside the window, I think that too is an area that we might want to look at and ultimately opine on as well.

MR. BUTLER: So, go back to seven, and these are the ones that you suggested, and actually I'm not sure I like them. I like your other list, but with the exception a little bit of the same day. Honestly, if a large orthopedic practice has an MRI in their office, I really don't have a problem with that if it's appropriately used.

If you could shift to nine, I just don't think capitation would work. The principle is right, but it's just not practical.

I think all of these are actually pretty good and worth pursuing. We've talked about them in the past.

Now I would add one, and I would reinforce what Herb just said. The treatment side errors of commission, I'm more worried about on the treatment side than over-utilizing diagnostic tools, with the exception of things like CT which also can do some harm if it's overused as a diagnostic tool. So things that can do harm to the patient,

potentially, if they're not used, should be an area of focus. In general, those are more on the treatment rather than the diagnostic side.

I'm wondering whether, under Measure and Report Physician Use, there's not a way to kind of specifically flag certain thresholds that would trigger an automatic review, which, by itself, would create some anxiety. I realize that would be controversial, but I think we'd learn a lot more. If there were certain patterns that were subject to review, it would inform us better about how we would then in fact address it through policies, advanced care, comparative effectiveness, in a more appropriate way.

I can name examples where I've seen, for example, oncologists who typically are involved more in chemotherapy, but when they in fact are sitting in a setting where the radiation is also there, it's not an either/or. Maybe it's both more often than otherwise would have been the case.

So there are situations like that. If we had the data, maybe it would help at least inform us and flag where we should be looking.

MR. BERTKO: If I can just add to what Peter said, I just went to a meeting where Washington State, in its

Medicaid program, is using just that kind of approach. I think it's on imaging as well. They do report cards, and, if you get an F on your report card, you are subject to prior authorization. There's a private reporting of that, and then the stick afterwards.

So there's a precedent, and it's Medicaid. It's another public program.

DR. CROSSON: Along some of the same lines, it seems to me again I must be in the two-by-two table mindset today, but it seems like we have another two-by-two table to think about. One is the distinction between whether we're talking about diagnostic, a diagnosis or a therapeutic intervention. The other one, the other axis is whether or not the diagnostic intervention or therapy is essentially always used or only sometimes used.

So, for example, if we have a diagnostic intervention that is pretty much always used, and I would think of in the orthopedic office, an x-ray of the knee. Generally always, for most conditions, you're going to get an x-ray of the knee. Trying to prevent that in some way would seem to me to be kind of interfering with the fundamental practice of that specialty, and I probably

wouldn't go near that box.

I think it's easier to think of when you're thinking about a diagnostic procedure that's only sometimes used because that's the area where, likely, the abuse occurs -- where it's more likely for someone, let's say, to be influenced to overuse something that's only used occasionally if the individual has that in the office and is likely to receive payment for that. It strikes me that that area is one area, and we've talked about it before, that you could deal with, with bundling, bundling of payment for those things.

In the therapeutic area, again, I think you've got sort of a distinction there. If you're talking about a physician engaging in a treatment or a therapy which is virtually always indicated for the condition that's being cared for, I mean I'm not sure how you can interfere with that. I mean that's basically in the interventionalist form of the practice of medicine. That's what that person is supposed to be doing, one would think.

It's in the fourth box where I think the most difficulty is, and that's where, if we use radiation therapy, Ron's example, that's where it becomes difficult.

It's where there's more than one treatment that could be used. Glenn, you said the same thing.

In fact, there may be untoward pressures to choose one treatment or the other based upon whether the individual happens to own the device that is engaged with that form of treatment and where I think some sort of subjective process has to take place to try to determine whether there's abuse or there isn't.

So I don't know if that's a helpful way to think about it.

DR. BERENSON: Just picking up on a couple of things that have been said, I appreciate the distinction between the therapeutic and the diagnostic, and the importance of really trying to figure out strategies, which I think are real difficult, around this issue of self-referring for a unique therapeutic approach when there are options.

But, while many of the, say, advanced imaging diagnoses don't cause patient harm, they sure drive up costs in appropriately.

So I guess this is a question. The Commission has a position recommending prior authorization for imaging?

No, it doesn't.

What has it said in this area?

DR. MARK MILLER: We've said a lot of things.

[Laughter.]

MR. WINTER: The first thing we said, we looked at this issue in our March, 2005 report, when we looked at private sector approaches to managing imaging. We considered a range of options, including prior authorization, and for prior authorization we felt at the time that the administrative costs were relatively high. We were concerned about the return in terms of reduced volume and the administrative burden.

Since then, we've had a couple of expert panels talk about this issue, 2007 and 2008, which featured, which included presentations from plans that are using prior authorization for imaging, from a former President of the American College of Cardiology talking about their approach to managing appropriateness of imaging.

Then last year, we Bruce Steinwald from GAO talk about their report on this, on the topic of imaging, where they recommended that CMS consider using front-end approaches to managing utilization such as prior

authorization.

DR. BERENSON: Okay. So I guess what I'd say is we've hadn't taken the leap, and I'm sympathetic of not doing it across the board without any distinguishing between who's appropriately referring and for whom it's going to be just a hassle for the patient and the doctor.

But it might be, as somebody over here said, we might target for practices that are generating a high volume of I'd start with advanced imaging and maybe a few other diagnostic procedures and say, at least initially, you'll then be in a prior authorization situation, and we'll gold-card you or whatever the term is if you're not abusing and come back every once in a while -- or, some targeted medical review. But I'd rather do it before the fact, prior authorization. So I would add that to the list.

MR. HACKBARTH: Another wrinkle on that, another version of that would be to say prior authorization for all high-end imaging in the case of self-referral. That's part of what you're buying into if you want to own the equipment and self-refer. You're also going to be carefully scrutinized.

DR. KANE: I think we should definitely try to

look into this. I'm not sure I want to -- I like the ideas of prior authorization.

I guess the other piece that no one has mentioned but makes me kind of nervous is that if someone has a high-cost piece of equipment they want to use, and Medicare starts pushing down, they might well decide to use it on the under-65 population.

So I'm wondering if this wouldn't be one of those things where we really should recommend that we partner with the private sector and also maybe even use them to help with prior authorizations or something, but that they should also be warned because when someone has got one of those cyber-knives and they want to use it to treat everything, they can go under 65 as well. If Medicare says I'm out of there, I'm going to put a lot of pressure on you or I'm going to exclude you, they could easily turn right around and use it on 58-year-olds.

So I just think you can't just leave the private sector vulnerable when you detect it.

MR. BERTKO: It's the other way around. The radiology benefit managers are already out in full blast with their Halloween costumes on.

DR. KANE: Well, for imaging, possibly, but I don't know about cyber-knives. I mean I don't know about some of the radiation technologies.

MR. GEORGE MILLER: I guess I would come down on the side of if we have evidence -- and I think you show in the report that we have evidence -- if a physician owns an advanced imaging piece of equipment, there's higher utilization, then I'm not sure prior authorization is strong enough, in my opinion.

I'm not sure if I'm ready to say that we should totally ban it, but I think prior authorization because it's just intuitive. It's fee-for-service. It's driving that additional utilization, how we put that genie back in the bottle.

I don't know what to recommend, but I want to be stronger than just prior authorization.

MR. HACKBARTH: Yes, the genie in the bottle is a big issue here. The options that you had before high-end imaging started to spread this way are different than the options you've got now. It would be very difficult, if not impossible, to outlaw it for people who have invested big bucks in this equipment, based on the rules prevailing at

the time.

Theoretically, that might be a good thing to do. Practically, it's going to be a real bear to accomplish. So you could try to limit the new people from buying it through pricing policy or whatever, and you can scrutinize those who already have it, but pretending that you can make it go away everywhere I'm afraid is not realistic.

MR. GEORGE MILLER: I think some combination of what you just said, Glenn, and then moving toward bundle payments or accountable care organizations as part of that solution.

MR. HACKBARTH: So you can use payment policy to influence the degree, the way in which it's used.

MR. GEORGE MILLER: Right.

DR. CROSSON: That's what I wanted to say. I mean even though they're in place you could still go diagnosis by diagnosis, and say don't bill for this MRI for this diagnosis because you're going to be getting a bundled payment for that diagnosis, and gradually expand the number of those diagnoses.

MR. GEORGE MILLER: Especially when, as Peter said, patient harm is one of the issues by over-utilization.

DR. CASTELLANOS: Obviously, I have a couple of things to say.

One is I'm struggling with the therapeutic and diagnostic. I really am struggling like that, and I'd like just to talk first on diagnostic. I think a front-end approach maybe a good end, a good approach to that. I know that's what the private insurance is doing, and it's successful.

We had a panel here maybe two years ago, if some of you remember, and I think that's when the cardiologist was here. But we had a primary care doctor from Minnesota, who was in charge of the imaging issue there, and he used a concept of prior notification, and then there was a concept of prior utilization, getting, just notifying that it needs to be done. He said about a 20 percent effect on decrease in volume.

So something, it's less onerous. It's something we should look at it. I didn't say we should do it, but that may be just as good or something that's less onerous than prior approval.

The thing about radiation therapy, once the patient is referred to the radiation therapist, it doesn't

come under Stark anymore. He's not seeing the patient, and the real issue here is that we don't have any comparative effectiveness data.

He could use something like seeds for prostate. He could use IMRT. He could use the cyber-knife that Nancy mentioned, and now there's a proton beam which is hundreds of thousands of dollars. We don't have any data to show which is better or not, and we really need comparative effectiveness data.

It's going to be very hard to influence the behavior of the radiation therapist because that patient is already out of the Stark exception and into the patient.

Now getting back to the physician that owns the radiation equipment, first of all, I want to say I do not own any radiation equipment. I don't own it. I work with a radiation therapy group, but I do not own it. Okay?

We've noticed this in urology. One of the real serious things that we're seeing is to supplement people's incomes physicians are going into ancillaries. As I've said in the past, if I'm going to take care of patients today and tomorrow, I have to stay in business. And, sometimes to stay in business, it requires me to increase my income.

I don't have to tell you about reimbursement for physicians. Since 2001, we finally caught up. We had a 5 percent cut then, and we finally caught up today. Based on the practice expense costs, it hasn't caught up. So, unfortunately, a lot of this over-utilization has been used maybe inappropriately to increase income to stay in business.

What I want to do with urology -- and I said something to Herb, and Herb mentioned this with another thing today -- is we would like to work with CMS, work with CMS doing a study with urology where we have the options of doing surgery, chemotherapy, nothing or radiation therapy, nothing being observation.

We're hoping our society can work with CMS and get a study like that done, so we can see what's actually out there because there's no data now on utilization on radiation therapy, and we do really need that data.

DR. BORMAN: Just trying to stick here with slide number 9, I would echo some of what Peter said earlier about some of those other slide options that I found less appealing than what is on here, and just a couple of things here.

Number one, I think we've always sort of espoused that, and there may be some details of what the standards are and so forth.

Number two, I think probably isn't specific just to this particular problem. We're already addressing. We've already just had the big several hour discussion about payment accuracy. So that's going to fall if we fix that in other arenas. Other than potentially a site of service adjustment, then that's going to fall out in some other work. I'm kind of looking for what is unique about this.

So the physician resource use, again, we're sort of looking at that and starting to look at that in another arena, and perhaps that report takes on an additional criterion of does this physician own ancillary services. Maybe that's something that comes out on the standardized RUR as that report evolves.

I think the last two probably are the ones that bring the most to bear, again, about considering, as Nick would have said, high-volume, high-cost disease episodes, working to look at those, both from the appropriate standpoint and what services typically come together, are as applicable here as they are in some of the other areas we've

talked about and probably where the biggest potential impact of this is.

I would throw out two cautions to some of the things that have been said. Number one, I guess I'm less sanguine about the diagnostic/therapeutic piece for a couple of reasons:

Number one, the increasing dose of ionizing radiation that patients are experiencing, including children, and what the downstream consequences of that will be.

Then, number two, when we do these things, we find incidental findings that generate huge dollar work-ups on a large number basis. For example, a CT scan of the abdomen has about a one in a thousand chance, ballparkish, of detecting in an adrenal gland abnormality. You aren't going to find that by physical exam, history or anything else. You're only going to find on the CT.

The screening recommendations to deal with that, because there are some potentially very bad diseases at very low frequency, now folds up into several thousand dollar easily to get it just the bare bones, so that the diagnostic piece does have some, at least, cost consequences and

potentially bad things for the patient who gets put into this mill of working up this incidental finding and comes to some intervention that maybe didn't need to be done in the first place, or at least an expensive diagnostic work-up that their co-pay and so forth has really been.

So I think the diagnostic piece is not quite so clean to me as maybe it is to some other folks.

The other thing was triggered by something that Herb said, about the going over there and scheduling it a week from now. I agree with you, there's something intrinsically kind of bothersome about that, but I also think we need to step back as we think about these ACOs or medical homes or whatever, that as we look at diagnosing or treating diseases, that you may want the one-stop shopping of scheduling things at that time shouldn't automatically disqualify you.

So, for example, I just throw out in my own world, if you went to the Mayo Clinic to get an evaluation potentially for primary hyperaldosteronism because it's a surgically correctable high blood pressure disease. It's important, day one, certain things happen; day two, certain things happen and so forth. So, by the end of day seven,

you've either had the diagnosis excluded or you've been fixed. That does have that, prospectively, we're going to do this on different days, but it comes out to a pretty high value for the patient package in terms of coming to closure.

So I think we just need to be a little bit careful about how we craft some of those things, that we don't get ourselves in a box relative to some of our future strategies.

MR. HACKBARTH: Okay, we're going to wind this up for today. I appreciate people's patience with our running over.

We will have a brief public comment period. I would remind people that we now have a new opportunity for people to comment on our work, and that is through the MedPAC.gov web site.

Hey, Jim, the way to get to that opportunity is how? Which buttons do you push?

DR. MATHEWS: The comment function is available at the same place that you find our meeting agenda. Each agenda item will have a box for you to submit comments via email.

We start soliciting comments at the time we post

the agenda, and we'll continue soliciting them for one week after the meeting.

MR. HACKBARTH: So please begin by stating your name and organization, and limit your comments to no more than two minutes. When the light comes back on, the two minutes is up. Thanks.

MS. LEE: I'm Gayle Lee, Director of Federal Payment Policy and Regulatory Affairs at the American Physical Therapy Association. APTA is a professional association representing more than 72,000 physical therapists, physical therapist assistants, and students of physical therapy.

I would like to take the opportunity to thank MedPAC for your interest in exploring the in-office ancillary exception to the Stark law and encourage you to look at physical therapy in addition to imaging. I know there was a lot of discussion of imaging today.

In recent years, there has been a dramatic increase in physician ownership of entities that provide physical therapy services. Under the in-office ancillary services exception, physician practices are legally able to open up multiple satellite offices that provide physical

therapy services with no physician on site at those satellite locations, and the physician practices are then able to refer to those satellite locations.

As you indicated during your discussion, there is an inherent financial conflict of interest with physician ownership in these entities to which they refer, and studies have indicated higher utilization and increased costs.

The in-office ancillary services exception was created to recognize that in some circumstances there is an enhanced patient convenience which may justify the risks presented by the inherent conflict of interest that exists. However, in our view, provision of physical therapy services by physician-owned practices is not more convenient for the patient. It is rare that a patient would begin to receive physical therapy services during a regularly scheduled physician visit. Instead, the patient makes a subsequent appointment and goes to the physical therapist, and there tend to be repeated and multiple sessions of physical therapy.

Therefore, to us perhaps the time-based approach that was mentioned earlier might make more sense as an opportunity to approach this issue.

APTA will be submitting more extensive comments, and we thank you for the opportunity once again to comment, and we look forward to providing additional information.

MS. McILRATH: I'm Sharon McIlrath from the AMA. I do not think in two minutes I can begin to address everything you talked about in two hours, so we will be putting some comments up, and I hope you will all read them. I will try to keep this briefer if you promise you will.

I just want to say that when you are talking about what the RUC does, you need to keep in mind that this is a group of people who know that there is a fixed pot of money. So any dollars that they give to one specialty or the time that is awarded in the discussion is coming out of someone else's pocket. And so there is a lot of discussion.

Also, as Kevin mentioned, they have done several screens to look at things that might be overvalued. One of those screens is high IWPUT, which is their word for high intensity per unit of time. So they are addressing it. The times are much better. They also have some packages of time that they put in for like a surgical procedure, the pre-service, so that it is becoming much more sort of standard and uniform across the times.

That being said, at least one of those things that was on your list, the CT of the pelvis, is on the list of things to be reviewed.

I wanted to just say on the colonoscopy I believe that one of the -- I don't remember the full debate about that, but I think -- I am sure that there is some difference in the two procedures because, one, the time that the RUC used includes moderate sedation as part of the time. Whether or not that eliminates or totally explains the difference I wouldn't want to say, but there is some difference in what is being discussed there.

Also, you need to keep in mind that it is a relative value scale, so that if colonoscopy is overvalued, it only matters if it is overvalued more than everything else. And if you take different studies, you can find a study that will say that almost anything is overvalued.

For the mid-level visit, the database includes 23 minutes of time. There are studies that would tell you that that is more time than is generally spent today on a mid-level visit. And once you start mucking with that, as Karen mentioned, anything you do with the E&M has a much bigger increase -- or, I mean, a much bigger effect. So you could

be moving a lot of dollars around, and you could actually do harm to the primary care services if you are not careful.

On intensity, I think every physician thinks that what they are seeing, the patients have more illnesses, more co-morbidities. One thing to keep in mind is that on an E&M visit, you have different levels, and so you can bill a higher level, and we are seeing that in the volume data.

Now, there is a problem, which is that every time that number starts to creep up, the OIG or someone comes along the racks, and they are going to audit people when that is going up. So if you think that that -- and we do think that that is really is happening. One way that you could help primary care physicians is to sort of try to call off the dogs on that one.

As someone else said, you probably should look at this again after the new rule comes out because there are some significant changes at least proposed in that rule -- about an 8- to 9-percent increase for internal medicine, and about an 11-percent decrease for radiology and cardiology.

And then, finally, I just wanted to suggest that if you look at the intensity levels over sort of the BETOS, the categories of service, as opposed to just picking out

individual services, I think what you would see is that it is not so different as if you just pick out one or two.

For instance, I think you would see that major surgery is about 17 percent higher than E&M and imaging is maybe 6 percent higher. So I would just encourage you to sort of look overall instead of at just the pieces, and then to say -- I mean, the RUC has also looked for different databases. The problem is you have got to have a database that is standard across everything as opposed to people picking and choosing. There have been some fairly heated discussions at the RUC about different databases and which databases you can use.

And then I guess, lastly, if any of you would like to have a lesson in how this stuff works, we would be happy to set you up with either the RUC staff or a RUC member to have further discussions.

MR. HACKBARTH: Thank you.

MS. WILSON: Hi, I'm Emily Wilson with the American Society for Radiation Oncology. I have a new retainer today so I can hardly talk, so we will be submitting comments to you.

ASTRO is the professional society for radiation

oncologists, and we are just really excited by the discussion today. We certainly have a lot of anecdotal information from our members that they believe that there is a significant problem related to self-referral with radiation oncology, in particular for prostate cancer patients, where you have several alternatives that are available and there is steerage to radiation therapy by non-radiation oncologists. And so we are heartened by this discussion, and we will submit comments. It is late. And thank you for your work.

MR. HACKBARTH: We are adjourned until 8:30 tomorrow morning.

[Whereupon, at 6:02 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, October 9, 2009.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, October 9, 2009
8:30 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, J.D., Chair
FRANCIS J. CROSSON, M.D., Vice Chair
MITRA BEHROOZI, J.D.
ROBERT A. BERENSON, M.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
PETER W. BUTLER, M.H.S.A.
RONALD D. CASTELLANOS, M.D.
MICHAEL CHERNEW, Ph.D.
THOMAS M. DEAN, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
HERB B. KUHN
GEORGE N. MILLER, JR., M.H.S.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 everybody.

Because we have a guest at the end of today, and because people want to catch airplanes, I'm going to do a better job of keeping us on time and the first step is to start on time.

Our first topic this morning is caring for medicare beneficiaries with mental illnesses and then we have two sessions related to provider concentration and related pricing issues.

Dana.

MS. KELLEY: Good morning. In January, 2005 CMS changed the method of payment for inpatient psychiatric facilities from a cost-based systems to a perspective payment system. Last fall I presented an overview of Medicare's coverage and payment policies for inpatient psychiatric services. My presentation this morning will be the first in a series of discussions we'll have as we prepare for a chapter on IPF care in the June 2010 report.

The June chapter will consider the adequacy of Medicare's payments for IPF services as a prelude to a future March report update chapter. But in our previous

discussion of IPF care, several of you pointed out the need to think about this issue more broadly. Peter, for example you reminded us that there's a much bigger story behind the IPF stay. And Arnie pointed out that in many cases the IPF stay is a consequence of failure on the ambulatory side. So our June report chapter will also consider inpatient psychiatric services in a broader context of general mental health services for beneficiaries with mental illnesses.

As you know the Commission's approach to assessing payment adequacy hinges on considerations of changes in the volume of services, changes in the capacity and supply of providers, beneficiaries' access to care, changes in the quality of care, providers' access to capital, and Medicare's payments and providers' costs. In the Spring we'll bring new information on providers' access to capital and Medicare's payments and providers' costs.

Today I will provide you with some information on volume and supply and then we'll discuss some of the broader issues related to access to care and quality of care in IPFs.

First, let's talk about volume and spending. IPF spending reached $3.8 billion in 2007. Spending has grown

almost 7 percent since the PPS was implemented, but the number of cases has declined about 6 percent. The decline in cases is due in part to growing enrollment in Medicare Advantage, which has decreased the number of beneficiaries enrolled in fee-for-service. But even controlling for fee-for-service enrollment we still see decline in cases of 2 percent. About a third of beneficiaries admitted to IPFs in 2007 had more than one IPF stay during the fiscal year.

The most frequently occurring diagnosis accounting for almost three-quarters of IPF discharges was DRG 430 psychosis, which includes schizophrenia and bipolar disorder. The next most common discharge accounting for 8 percent of IPF cases was DRG 12, degenerative nervous system disorders including such illnesses as Alzheimer's Disease, ALS and Parkinson's Disease. Among the top diagnoses, degenerative nervous system disorders experienced the most growth between 2004 and 2007, rising 29 percent.

As you know inpatient psychiatric care can also be furnished in so-called scatter beds, that is in acute hospital beds that are not within Distinct Part Psychiatric Units. Medicare pays for scatter bed services under the acute hospital PPS. We looked at scatter bed cases in 2007

to see if some of the decline in volume of IPF services was due to a shift to scatter bed care. We found here, too, that the volume of services has declined, but only a third as much as in IPFs. And on a per fee-for-service beneficiary basis the number of scatter beds actually has grown 1.5 percent since the IPF PPS was implemented.

However, the pattern of care in scatter beds differs markedly from that seen in IPF, which suggests that the mix of patients may be different and therefore not directly comparable. As you can see here the distribution of diagnoses is quite different. This slide shows the top five scatter bed diagnoses and the share of those diagnoses in IPFs in 2007. You can see that scatter bed patients are far less likely to be psychotic, which is as we would expect since most acute care hospitals cannot accommodate involuntary admissions in scatter beds due to inadequate security. But these diagnosis patterns also suggest that patients admitted to scatter beds may have underlying medical conditions that are more appropriately treated in the acute care hospital.

For example, beneficiaries admitted to scatter beds are far more likely to be diagnosed with degenerative

nervous system disorders and alcohol or drug abuse complicated by comorbid conditions. We also found that patients in scatter beds tend to be older than those in IPFs. They're almost twice as likely to be age 80 and older. In addition, lengths of stay in scatter beds are much shorter than in IPFs. This may be because some patients may be admitted to scatter beds for a brief stabilization period before being discharged to a longer term setting. Scatter bed patients are much more likely than IPF patients to be discharged to a SNF, for example.

Some part of the difference in length of stay may reflect differences in payment in the two settings. Scatter bed cases are paid on a per discharge basis under the hospital PPS, while IPF cases are paid on a per diem under the IPF PPS.

In evaluating changes in the volume of IPF services furnished, it will be important to consider other changes in the use of health services that might affect admissions for acute mental illnesses. Among these services are psychotropic drugs, outpatient mental health services, and partial hospitalization. Psychotropic drugs including antidepressants, antipsychotics and anti-anxiety agents are

the predominant form of treatment for many mental health and substance abuse disorders.

Use of these drugs has grown sharply over the past decade and implementation of Medicare Part D may have increased beneficiary access to them by reducing out-of-pocket spending. Greater access to these drugs may reduce the need for inpatient psychiatric care. Other outpatient mental health services include psychiatric evaluation, diagnostic testing, psychotherapy and medication management.

Until recently Medicare required cost-sharing of 50 percent for outpatient mental health services, which likely discouraged use of the services. MIPPA, in 2008, requires that the cost-sharing for Medicare beneficiaries using mental health related treatments on the outpatient basis should be reduced to 20 percent by 2014. That reduction should improve access to outpatient mental health services, which in turn may reduce the need for inpatient psychiatric care.

Medicare also covers partial hospitalization services if the beneficiary would otherwise require inpatient psychiatric care or if the beneficiary has been recently discharged from inpatient care and needs partial

hospitalization to avoid a relapse. We plan to examine changes in the use of these services as part of our evaluation of changes in IPF volume.

Now let's look at IPF supply. Nationwide the number of IPF beds has remained fairly constant since the PPS was implemented. But we are seeing shifts in where those beds are located. Despite growth in the number of Critical Access Hospitals with psychiatric units, the overall number of beds in rural areas has declined. The number of beds in distinct-part units has also declined. Although as you can see on the lefthand side of the slide, these units still care for 72 percent of all IPF cases. We also see that the number of beds in not-for-profit IPFs has declined 10.5 percent, while the number of beds in proprietary IPFs has grown 12 percent.

Because an inpatient psychiatric stay is in many cases a failure of outpatient treatment of mental illness, it is appropriate to consider whether beneficiaries with mental illness have adequate access, not just to inpatient services, but to the outpatient care that they need.

More so than in general medical care, access to mental health care is a function not just to provider

availability and patient ability to pay, but also patient willingness and ability to seek care. The stigma associated with psychiatric diagnosis and treatment prevents many people with mental health disorders from pursuing care. In addition, the nature of mental illness is such that some sufferers do not perceive a need for care or if they do, have difficulty navigating the health care system and maintaining a treatment regimen.

Some people with mental illnesses don't pursue or continue to treat because of intolerable or undesirable side effects from medication and ethnicity, race, culture, and language barriers can also play a role in a patient's willingness and ability to seek care. In part because of these issues, research suggests that treated prevalence of mental health conditions remains well below underlying population prevalence.

Several recent studies have found that minorities reported overall lower rates of lifetime mental health disorders than whites. These findings may not be definitive, however, because ethnicity, race, culture and language may affect a person's behavior as well as one's reporting of symptoms and the interpretation of those

symptoms by others. Also, accurate measurement of racial disparities is undermined because community surveys generally exclude the homeless and the incarcerated populations whose members are disproportionately minority and known to have high levels of mental illness.

When minorities do become mentally ill, researchers have found that they are less likely to receive needed care in part, because they are more likely than whites to delay or fail to seek mental health treatment. But minorities who do seek that treatment are more likely to receive poor quality care, they are more likely to be misdiagnosed, and less likely to receive appropriate evidence-based treatments for their conditions. These disparities may help explain why African Americans who have mental health disorders tend to have more persistent illness compared with their white counterparts.

We looked at admissions to IPFs by patient race. The racial composition shown here looks disproportionately minority, but it reflects that of Medicare's under 65 population. In 2007 African American beneficiaries represented almost 18 percent of IPF patients, 2.5 percent of patients were of Hispanic origin. Diagnosis patterns do

differ by race. Minorities are more likely to be admitted for psychosis than whites are and they are less likely to be admitted for degenerative nervous disorders. In part, this reflects the fact that minorities admitted to IPFs tend to be younger than white IPF patients.

When considering access to mental health services, dual eligibles merit special attention. These beneficiaries by virtue of their eligibility for Medicaid coverage tend to be poor and to report lower health status than other beneficiaries. They're also more likely than the rest of the Medicare population to suffer from mental illness and cognitive impairment. Approximately 60 percent of disabled dual eligibles and 20 percent of elderly dual eligibles have mental disorders.

Dual eligibles have coverage for mental health care, but they may still have difficulty accessing the care that they need. Medicaid is responsible for covering Medicare coinsurance requirements for these beneficiaries. But state Medicaid programs do not have to pay coinsurance if Medicare's reimbursement for the service meets or exceeds the stat's Medicaid rate. Total payment to mental health providers may therefore be limited to the Medicaid

reimbursement rate, which for mental health services is generally very low relative to Medicare. As a result mental health providers may choose to limit the number of dually eligible beneficiaries they treat or to not treat them at all.

Under Medicare Part D, dual eligibles may now have better access to psychotropic drugs. But navigating a new drug plan may pose difficulties for dual eligibles with mental illnesses. Shinobu and Joan told us last month that beneficiaries receiving the low income subsidy including duals report less familiarity with their drug plans under Part D than do non-LIS beneficiaries. Dual eligibles with impaired decision-making ability may have even greater difficulty understanding their plans.

Coordinating coverage and payment policies across Medicare and Medicaid may be a challenge for dual eligibles and their health care providers. The challenges may be complicated by the fact that dual eligibles may have access to rehabilitative and psycho-social services through other state and local agencies.

The Commission has noted before that many coverage and payment issues for this population could be alleviated

if duals were enrolled in one integrated plan that covered both Medicare and Medicaid services. This integration has occurred in demonstration projects as you know, such as PACE and in Medicare Advantage Special Needs Plans. However, these plans serve only a small fraction of dual eligibles and none focuses on care for people with mental illnesses.

Finally, let's consider quality in the IPF setting. In the current environment assessing the quality of care received by Medicare beneficiaries and inpatient psychiatric facilities if difficult. There are a few meaningful, frequent, and easily collectible clinical outcomes measures that have been assessed for validity and reliability. Even if these measures did exist, CMS lacks the information it would need to adjust patient scores for severity of illness. There is no standard assessment tool used in IPFs.

Industry groups have been pursuing the development of process measures such as proper intake and assessment procedures, discharge and aftercare planning, use of restraints and seclusion, and appropriate drug regimens. But Medicare cannot use these types of measures because the information is not available on claims data.

In addition, by virtue of their Medicare eligibility most of the beneficiaries cared for in IPFs are chronically mentally ill. Effective treatment is ongoing, continuing long after a patient is stabilized and discharged from the IPF. So the IPF may have relatively little control over patient outcomes in the longer term.

Improvement in the overall quality of care received by beneficiaries with mental illnesses may require a more coordinated approach than is typically found under Medicare fee-for-service. The Commission has recommended that CMS establish a medical home pilot program for beneficiaries with chronic conditions, including chronic mental illness, to assess whether beneficiaries with medical homes receive higher quality, more coordinated care without incurring higher Medicare spending. Although a medical home model for collaborative mental and medical health care may prove cost effective from a societal perspective many of the benefits of better coordinated and integrated care for people with mental illnesses may accrue outside the health care system.

For example, through improved employment outcomes or reduced need for social services.

So some analysts believe that targeted financial incentives might be necessary to induce providers to develop a type of medical home for people with mental illnesses.

So in summary, since the IPF was implemented IPF cases declined about 2 percent controlled for fee-for-service population. Degenerative nervous system disorders have increased 29 percent. There's been little change in overall supply of IPF beds, although there's been a change in the distribution of those beds. Scatter bed cases increased 1.5 percent, which may be taking up some of the decline we've seen in the IPF setting. Part D drugs may improve access to psychotropic medications and MIPPA reduced cost-sharing for outpatient mental health services.

Finally, we know that access to mental health care is complicated, particularly by patient willingness and ability to seek care and by ethnicity, race, culture, and language barriers that exist, and we have few reliable quality measures. So now if anyone has any comments about this presentation that will be helpful to us. Also, information you would like us to pursue in the future and I'll just turn it over to you.

MR. HACKBARTH: Thank you, Dana. Good job.

So let me see hands for first round clarifying questions. We'll start with Karen.

DR. BORMAN: If someone were admitted to a scatter bed and then, for whatever reason, was then moved to the sequestered facility part of the institution, how would they look? How would they count in this? Do they end up counting in the -- staying in the scatter bed, sort of however you got labeled when you got admitted is how you stay or would they transition to looking as if they had come directly into a dedicated in-hospital unit?

MS. KELLEY: It would be a discharge from the scatter bed and then an admission to the IPF unit.

DR. BORMAN: Do we have any way of every, at some point, capturing that number as a potential group where there might be quality or questions? Some of them would be very appropriate I imagine.

MS. KELLEY: Sure, I see what you are saying.

DR. BORMAN: You had to park somebody there, because there was no bed. You put them with a one-on-one sitter, whatever those needs needed to be, but it seems like there probably is at least on some diagnosis-adjusted methodology, some level in there that is okay and maybe that

2X that level is no t okay. Just looking for things that would relate to the data you've already shown us that we might morph into an assessment of what's going on here that might reflect quality.

Just a thought.

MS. KELLEY: It's something we could look into. I think we would have to link up the claims data for that, but it's certainly something we can look into to.

DR. STUART: You make several statements in here in terms of increased accessibility because of Part D. Do you have plans to do a data analysis of that question?

MS. KELLEY: For this analysis, no. That would be a much bigger undertaking. I don't know if Joan has any plans in the future.

DR. SOKOLOVSKY: [off microphone] I don't know that we have any plans to separately look at that issue, as opposed to our ongoing Part D analysis. But it's certainly possible.

DR. STUART: I have some ideas about that and I will wait until the second round.

DR. CASTELLANOS: When you talked about access to mental health you talked about provider availability. Is

that a workforce problem?

MS. KELLEY: The reading that I've done suggests it's a very complicated problem. There does appear to have been a decrease in the number of physicians who are providing therapy services, but at the same time there has been an increase in non-physician providers. There's also concern that researchers have raised about appropriate training for treatment of people with chronic mental illnesses. So it seems to be a very complex issue and so I'm not really sure how much of a workforce problem it is.

DR. CASTELLANOS: I'd like to pursue that on level two.

MS. KELLEY: Okay.

MR. GEORGE MILLER: You made a comment that the minority population is more likely to receive poor quality care in spite of evidenced-based medicine. To that extent can you give me just for clarity, I'll talk about that in round two, but the magnitude of the number is it 51 percent or is it 90 percent when you said it's more likely? Do you remember the statistics?

MS. KELLEY: Offhand I don't remember, but I can look up that information for you and get it to you.

MR. GEORGE MILLER: And then just quickly on page 12 the slide about dual eligibles, do you have the demographic information for dual eligibles also since they are less likely to get adequate care?

MS. KELLEY: I don't have it with me.

MR. GEORGE MILLER: I saw that. I'm wondering if you have it for dual eligibles and my follow up question, I think I will do it in round two has to deal with are there disparities in the dual eligibles as prevalent as they seem to be the larger population.

MS. KELLEY: I don't know that I have the answer for that today, but it's something I can look into.

MR. GEORGE MILLER: Thank you.

DR. MILSTEIN: In the current design of the CMS medical home pilot, is there any form of evaluation or certification of the capability of the medical home to better diagnose and treat this category of problems?

DR. MARK MILLER: I think Cristina is the person who has the most information on that, but I have to say in all of my discussions and what I'm aware of there is not.

MS. KELLEY: I don't think so.

DR. BERENSON: I have two questions. One is do

you know off the top the payer mix to IPFs, Medicare, Medicaid, private, self pay?

MS. KELLEY: Off the top of my head I do not, but I do know, well I shouldn't say I know this. I have read that Medicare represents about 30 percent of IPFs payments.

DR. BERENSON: So it's sort of the overall average.

A second question, I actually see ACOs as promising or more promising as the entity that could do a better job. Do you know if there is literature around the performance of well-established, multispecialty groups or IPAs how they deal in this issue?

MS. KELLEY: I can look into that. I have read a few things but I don't know sort of how useful they will be so I will look into that for you.

DR. BERENSON: Thank you.

MR. BERTKO: Dana, I'm a little confused on one of the subcategories of the mental health ones, which is the degenerative diseases which I'm thinking of as -- at least I have interpreted as Alzheimer's, dementia, and things like that. So I can think of at least three categories where people fall into, which is this one into nursing homes being

institutionalized and then we've heard reports that many of them are in hospice as well.

And so, I'm curious on, you know, is it true that people could equally fall into one of those three categories or are there more people of graver illness in the IPFs? Do you know how that breaks out and why people are channeled to one versus another?

MS. KELLEY: I don't know why. I have spoken with some analysts who think that, in many cases the placement of people with Alzheimer's disease for example in IPF units is perhaps not appropriate and is related to a lack of experience in treatment and treating these conditions in nursing homes. So that may be something for us to look into.

The rise in the number of these patients in IPF settings, you know, certainly raises one's interest in the issue.

MR. BERTKO: Just as a follow up, I note that while your charts here show 8 percent in the IPFs, I think it was 25 percent in the scatter bed.

MS. KELLEY: Yes.

MR. BERTKO: Following the assumption that people

get into a scatter bed first and then they are discharged, that sounds like maybe there is some room for channeling there almost akin to how Bob was suggesting some care coordination could help with that.

MS. KELLEY: Okay.

MS. HANSEN: Actually, my question was exactly John's first question because I tied it back to hospice and the fact that on the same chart that share of population that is 25-plus percent is disproportionately 80-plus, so it does seem to have that theme. I definitely would like to kind of look under that a little bit more, relative to even the coding process.

MS. KELLEY: Okay.

MR. BUTLER: I was surprised, if I read it right, that 64 percent of the Medicare beneficiaries in IPFs are under 65, is that right?

MS. KELLEY: Yes.

MR. BUTLER: Almost two-thirds.

MS. KELLEY: I didn't show this before, but I have a little break down here of IPF discharges by age.

MR. BUTLER: You got my attention, two-thirds which says to me that obviously the various distinct-part

units or scatter beds or IPF, they really are treating significantly different populations as you point out.

MS. KELLEY: Yes.

MR. BUTLER: And some of it is age, some of it is diagnosis. So it's the distinct units which are paid so miserably are being phased out and you have a 7 percent decline in the last three years. I would be interested to have any sense of where those people are landing, if at all. I know that the volume down in the IPFs themselves, too but maybe it would have been down even more. I don't know.

MR. KUHN: One quick question. On page 13 of your slide deck, you talked about the efforts to begin trying to get quality measures and capture some information in this area and you talked about some of the areas that people are looking at. But you didn't mention this and I was curious, are they also looking at a CAHPS survey possibility for IPFs as well?

MS. KELLEY: I don't know. That's something I will look into.

MR. KUHN: Thank you.

MS. BEHROOZI: In the paper, you mentioned that the Surgeon General and others have recommended that

disparities in mental health care be addressed in part and the first item is reducing financial barriers to care. And, you know, in the private sector undergoing the transition mandated by the Mental Health Parity Act has made us more aware of these things. So seeing that beneficiaries were sharing 50 percent or are right now, sharing 50 percent of the cost of outpatient and that's going to go down to 20 percent by 2014, makes me wonder what the other components of additional costs relative to, you know, medical and hospital benefits are.

Do you have sort of a list of how their inpatient cost sharing, which I saw in a footnote but I didn't have time to digest it, how that relates to regular inpatient cost sharing or drug cost sharing? Maybe that's more of the analysis that you don't have done now. But do you have a sense of that?

MS. KELLEY: No. That's something we'll have to look into.

MR. HACKBARTH: Round two questions and comments. Bruce.

DR. STUART: I'd like to follow up briefly on the issue of using Part D data to better understand how these

people are being treated and there's a long-term and short-term aspect to this.

In the long term it would be really interesting to see whether the decrease in cost sharing on psychotherapy, and how that works in terms of increased accessibility to antidepressants and other antipsychotics, other medications used by these individuals. It's not that I'm not trying to set priorities for the Commission in this regard, but I think it's pretty difficult to understand what's happen with respect to treating these people without the Part D data and just simply saying that there's increased accessability doesn't help, I think, a lot from a policy standpoint, particularly when we've got the data to do it.

The second part of this is that the underlying etiology of these conditions is not at all well understood and there's some thinking that the underlying causal factors also are associated with other common chronic diseases and we certainly know from empirical analyses that there is a strong correlation between having certain chronic conditions and having a depression, just not sure which causes which or whether there's some common underlying cause but nonetheless they co-occur.

And so, simply treating mental illness is really only part of the issue. The other part is how are the comorbid conditions being treated, and we just finished up a study for CMS which finds that after Part D was implemented, that, in fact, there were still differences in terms of treatment for other chronic conditions for people who had depression, and, so, it's not just looking at depression medications, it's also looking at medications for those co-occurring diseases.

And then I thirdly and lastly would follow-up on a point that John made, and that is where these people are.

Now, since many of them are under 65, one assumes that they're not in nursing homes, but we just don't know, and it would be really interesting to see where IPF patients in particular are coming to and where they're going, and I think that's --

MS. KELLEY: The majority of IPF patients are discharged home.

MR. STUART: Right.

MS. KELLEY: So, most of them are not residing in facilities.

DR. STUART: Well, in this particular case, we

don't know what “home” really means. I think that’s a--

MS. KELLEY: Exactly. Exactly.

DR. STUART: Right. Okay, but the Part D thing, I would like to -- and we could talk about that afterwards.

DR. CASTELLANOS: Just making a couple of statements. Being in the practice world of medicine, this is one of the most vulnerable groups, poorly-managed groups in the Medicare System.

Access to care, at least in my community, is almost non-existent. You cannot get a psychiatrist to come to the hospital, you can not get a psychiatrist to cover the emergency room, and when I make a referral like Tom or any physician makes a referral, usually, you just can write or give a telephone number. I have to call and almost beg to get these patients in.

Now, is it a problem with workforce or is it a problem, as Peter implied, maybe financing reimbursement?

MS. KELLEY: Like I said before, this is something that we can look into a little bit further. Some of the reading I have done suggests that more and more psychiatrists are working more in medication management now than they are in providing psychotherapy to patients, and

that more non-physician providers are caring for the therapy side of patients' needs.

There has been a large increase in the number of social workers and other types of non-physician providers, but how that's working out in terms of an overall workforce perspective, I don't know, and it's something we can do some more looking into.

DR. CASTELLANOS: We even have problems with mid providers.

MS. KELLEY: Yes.

DR. CASTELLANOS: Mid-level providers. And this third question, just a clarification, I know when we talked about the primary bonus for primary care, I don't recall, was psychiatrist in that act?

MR. HACKBARTH: What I would say, and, Kevin, I don't know if you want to say anything here, but our definitions that we talked through in the report had to do with the delivery of certain types of services, and if you had a percentage above that, you are eligible for the bonus.

Would a psychiatrist be able to qualify under those definitions?

DR. HAYES: Only if they bill for a certain

category of office visits, home visits, or visits to patients in non-acute settings. And, so, the question would be--I don't know if you know this or not--whether mental health care professionals know billing codes for outpatient services or whether they use other billing codes.

MS. KELLEY: There's standard visit codes, aren't they, that you're talking about?

DR. HAYES: Right.

MS. KELLEY: I think that the therapy codes are different.

DR. MARK MILLER: Yes, they are. So, then that way they'd know.

DR. BERENSON: They use a different set of codes.

MS. KELLEY: Yes.

DR. MARK MILLER: Than it would under the stuff we worked out a year, year-and-a-half ago, it would be unlikely unless they were using those codes for some reason.

DR. CHERNEW: I have a quick follow-up question on Mitra's point, and then a comment.

The follow-up question is: On that slide 7 where you talked about MIPPA requirements for cost sharing going from 50 to 20 percent, most Medicare folks have supplemental

coverage. So, are they actually paying the 50 to 20 percent or--

PARTICIPANT: [Off microphone]

DR. CHERNEW: No, that's what I'm saying. So, I was trying to figure out how many people are actually facing the 50 to 20 percent cost sharing versus having some other?

MS. KELLEY: Well, I think here, it depends. This slide is talking more about the general Medicare population who might be suffering from mental illnesses as opposed to specifically the users of IPF Care. Many of the users of IPF Care, they're not going to have supplemental insurance, but many of them are covered by Medicaid or they're dual eligible or they have--

DR. CHERNEW: [Off microphone] [inaudible].

MS. KELLEY: Right, but I'm saying not private supplemental insurance.

DR. CHERNEW: Right.

MS. KELLEY: In this context, I was talking more broadly about trying to keep people out of the hospital and having acute needs. So, it's a very good question. You're right, that many of the patients who end up in the IPF are not going to be affected by this.

DR. CHERNEW: The comment I have, which relates to several of the comments that were made, starting with John's, is: I think this illustrates part of a discussion we had last month about the importance of thinking about these as people with certain conditions as opposed to--I don't like the labeling if you're an IPF user because you could have the same thing and be in a different place.

MS. KELLEY: Yes.

DR. CHERNEW: And what I don't know the answer to is: There are many questions about where you should be clinically, and then there are other questions about how the financial payment system influences whether you're going to the right place. Maybe it doesn't even matter, but I think the right denominator for thinking about some of these populations isn't you're an IPF user or something else, but you're a person with a condition.

MS. KELLEY: Sure.

DR. CHERNEW So, you could be under-treated, you can be in the right or wrong place, and, so, I think this just illustrates some of the episode of care discussion and some of the other orientation we have where we're being particularly non-clinical in our orientation about these

people.

MS. KELLEY: Yes.

DR. CHERNEW: And I wanted to raise that.

MS. KELLEY: And that's a data issue as much as anything else.

DR. MARK MILLER: The only other thing I was going to say is, and maybe it didn't come through, I think we've heard that comment, and one way to look at what Dana has set up here, and we're wading into or tiptoeing into this area, she's going to look at it from the perspective of the Medicare and Medicaid and the dual eligible perspective. We are going to try and look at this in an episode basis, and even though we don't have specific research plans to answer your question, Bruce, already internally, we've been discussing like would we be able to track the drugs for this population?

Now, what I think Dana is saying is the ability to bring all that data together and make it fit like a puzzle, that's what's going to be very complicated. We'll have scattered data on this population from different perspectives, including the IPF, and the uncomfortable thing is we're going to eventually have to make statements about

what to do on IPF payment, and, so, we'll be trying to manufacture these puzzle pieces. I guarantee you they will not fit together well, but I think the idea of this presentation is that's the tactic we're taking, trying to get a broad picture of it.

DR. CHERNEW: But, in the data, is there someone who is in an IPF that's linkable to someone who's in a--if that person was discharged from the IPF, went to the community, and then later ended up in a nursing home?

MS. KELLEY: Sure, but we'd have to link several datasets together in looking for the beneficiary ID.

DR. MARK MILLER: Depending on how robust the data is when they hit the nursing home and whether they're a Medicare patient at that point--

MS. KELLEY: Exactly.

DR. MARK MILLER: Which often they aren't, you may see a continuum of experience with a blank, and then other data, and that we're going to try to fill those gaps in.

MS. KELLEY: Right. Right.

DR. MARK MILLER: Conceptually, we are trying to look at it the way you have said, and you will all have said in many other meetings, but the ability to do that will be

somewhat limited.

MS. KELLEY: Well, see, like Mark said, there might be a blank and you won't know whether they're still in a nursing facility, but under Medicaid, because we don't have that data or if they've gone home. We can't--

DR. STUART: Let me just comment on that very briefly. This is a relatively small proportion of the Medicare population that we're talking about.

MS. KELLEY: Yes.

MR. STUART: So, that's a challenge, but MCBS does have a residence timeline which makes it actually quite easy to follow people over time.

MS. KELLEY: Yes.

DR. STUART: From one kind of setting to another. The sample size is an issue.

MS. KELLEY: That's my concern, and I have not looked into it.

DR. STUART: But if you put several years together, at least you can get some idea about what relatively small populations look like. I think without going to the immense kind of data manipulation that you're talking about.

MR. GEORGE MILLER: Just a follow-up on my earlier point, as we determine or if we determine that we should set quality measures and link that to payment and/or assessment tools, I want to strongly suggest that this slide on page 10 or slide 10 deal with these issues because I am personally troubled that folks with evidence base still get poor quality of care, and, in my mind, there should be a link to that, and I can't find a defensible excuse for it, quite frankly, and it really troubles me personally.

And then with the other bullet points, most likely to be misdiagnosed, I don't understand that. Less likely to receive appropriate care, I don't understand that. And, again, the statement was made with evidence care still receive poor quality of care, and I really don't understand that.

So, as we develop those robust measures, and I hope they will be robust, although I understand why it's difficult, if policy can make a difference, it certainly should make it here.

DR. MILSTEIN: And this is a challenge because the question we've been asked, you can intuit, is not the question we ought to be answering. The question we've been

asked is adequacy of payment to IPFs, but, as you begin to touch on it, you realize that you're really in a much bigger zone, and the bigger zone is access and poor quality of care to meet the behavioral health needs of Medicare patients.

And, so, it seems to me there's one very important sort of divide in the road here as to whether or not we go after the main problem or whether we stay narrow and simply focus on adequacy of payment for IPFs.

MR. HACKBARTH: So, what I hear you saying is that doing that narrow focus may be worse than inadequate, it may actually be counterproductive.

DR. MILSTEIN: That would be my intuition. I mean, and, in some ways, I think of if we are a team, we're a team whose sort of area of specialization and primary focus is on how you handle problems of overproduction of services and inefficient production of services. I call it our core expertise, and here, through this particular change, we realized we're in a territory where the primary problems may be more related to access and quality of services. And, in essence, we know this is an area where there's a lot of evidence that the benefit is not buying the kind of health that the benefit could and ought to be

buying, and I think the prior exchange about adequacy of our usual sources of data is right on the mark, particularly when we know that a fair percentage of the quality problem is embedded in under-diagnosis and misdiagnosis.

So, what are our traditional data source is going to do for us? I mean, I agree with the comment about Part D data, but I think if you have a fundamental problem of under-diagnosis and inappropriate treatment and wrong diagnosis, the Part D data is going to be of less use to us.

And, so, my intuition would be to make a decision whether we're going to go after the big problem or staying narrow, and if we want to go after the big problem, then we probably need supplemental sources of expertise and data to shed light on the quality and access problem, because I don't think we really have a handle on that right now.

MR. HACKBARTH: Let me ask Mark and Dana to comment on this.

So, as I understand it, Mark, the plan has been to move towards doing the payment adequacy analysis of the in-patient VIP of rate. You heard Arnie's concerns. What are your reactions to it?

That's not required, by the way. That would be a

choice for us, wouldn't it?

DR. MARK MILLER: Well, that was the plan. The plan was not to do it this fall because we feel like we're just kind of working our way into this, working our way into this area. I mean, Congress has given us a broad mandate in the sense of saying please advise us on these payment areas. As you can see, we tend to do things, move into areas as we have resources and ability to do this.

So, what we could do here is take your thought and a narrow versus broad and kind of internally talk a bit more about how robust--whether there is some gain, even on a narrow basis because when you think about this, to a greater or lesser degree, we're often always dealing with this problem that there's something embedded in Medicare that we're responsible for in a sense, but it sits in a broader context. Some of it is more self-contained than others. This one in particular, as somebody said, I can't remember which commissioner, when this happens, this in the middle of an episode and actually could represent a failure as opposed to ongoing care.

So, the couple of threads are this notion of trying to assemble blocks of data around this population as

best we can. Another thread to keep your eye on is that we have push now that we're going to start working on the dual eligibles more broadly in looking at how coordination can occur for those populations at the state level. There may be something there, even though it's not IPF that we're talking about, but the broader issue. We're going to try and bring that together because there may be programs in states or coordination efforts in states that we can look at and say all right, is there some opportunity here?

Now, having said all of that, I don't want to over-promise, and I think that the progress in this area in particular may be very slow and incremental, which tends to frustrate all of you guys, but we will continue to do our best on that.

On the narrow front and broad front, I would say let us take that question back and see if there are narrow things even within the Medicare context that we can make it better, but with the understanding that we get the point that this is a broad area and we need to be thinking about that that way.

MR. HACKBARTH: I think Arnie has raised a critical question here.

Dana, could you put up slide 8?

So, my instinct is that you're right, that looking at the narrow piece could be problematic.

Having said that, I look at some of the numbers on the right-hand column, and I wonder whether they signify that this new payment system may be having unintended consequences. A statement of fact, but there's some pretty significant shifts here in a relatively short period of time that raise questions in my mind.

MR. KUHN: Glenn, if I can just comment on that, I mean, I think Arnie's onto something, as well as you are here, is that also we have to remember, this is a new prospective payment system, it's the latest one that CMS has launched, and, so, anytime you have a maturing and new prospective payment system, you will have unintended consequences, and I think part of our analysis needs to look at what's happening in those areas that are dipping down or those ones that are seen in growth because that could all be driven by the opportunities that are presented in the new prospective payment system. So in addition to doing a payment adequacy, I think we really need to think about drill down as deep as we can to kind of understand some of

this variation that's going on.

DR. KANE: Actually, that was pretty much what I wanted to say, is I think we--to both try a population-based approach of what's going on with that population, which is sort of what the title of this says. But I agree that particularly the minus 10 on the non-profit and the plus 12 on the for-profit always makes me nervous because we need to know why is that that people see an opportunity to make money here and that the non-profits are dropping out. So I'd want to know at least why that trend is happening.

And I guess the last thing is there are already SNPs dealing with dual eligibles, and I don't think they're screaming out mentally ill necessarily, and I'm wondering if there isn't some kind of information that we could get, even the PACE Program, but certainly the SNPs are doing dual eligibles, like in Massachusetts, where they actually are doing Medicaid, Medicare. It might have some sort of population-based ideas of what an episode looks like for people with any kind of diagnosis of primary or secondary, I guess, however you want to pull that, of mental illness, and maybe that's where we need to go to get some of our early signs of what's happening on more of a population or episode

basis.

DR. BERENSON: Yes, just picking up on the topic you introduced here, while we do that analysis, I would just point to the other things that could be going on. The health system change, I think, is pretty well-documented that a number of general hospitals are dropping distinct-part units, be it cost of cutbacks or inadequate Medicaid funding, and under service line strategies, they're just giving that up. So, I don't know that Medicare is driving this whole phenomenon.

The point I was also going to make, I wanted to address the patient center, medical home issue. I mean, there is a literature about the significant under-diagnosis of depression in primary care practices. RWJ actually a whole national program addressing this issue, and there's also at least anecdote and probably literature from the disease management companies that depression, as a comorbidity, is a major confounder of the ability to improve care for congestive heart failure, COPD, et cetera, and as there's a general trend to try to move that disease management activity into the practice, I think the medical home becomes a model for that. So, there's a real

opportunity here.

My concern in talking about the medical home is that everybody's got a favorite thing that they want the medical home to do. Cultural competence, shared decision-making, better diagnosis of depression, et cetera, and that we don't so lower the expectations on the medical home that it collapses under that weight.

I do think in this area we need to distinguish depression, which I think is fully within the competence of a good primary care practice from psychosis, which you need, I think, a full ACO mobilized to handle, and I would not expect most primary care practices to deal very effectively with patients with schizophrenia and severe bipolar disease.

So, that's it.

DR. CROSSON: Just an observation, the one thing that you note in the summary, Dana, on slide 14 is that the most significant change in case mix that's occurred since the institution of prospective payment has been an increase in DRG 12, degenerative nervous system disorders, and I wondered, reflecting back on our discussion earlier of hospice where we had, I think, begun to suspect that some of the increase in hospice care was actually directed at the

care of patients with Alzheimer's Disease, whether in fact that phenomenon is also taking place here, and, more broadly, whether in fact there is an increasing burden of Alzheimer's Disease across other Medicare payment sectors and whether that's something that we might want to take a look at later on.

DR. SCANLON: Just to add something to the discussion about taking a broad approach, I think that when we do that, what we're going to discover is the important role of state policies and how much their variation is going to be, and I think in this area, it's not just a question of what happens to dual eligibles, though it's profound for them, there's spillover effects. Your residential sort of care options are very much influenced by what states decided to do with respect to Medicaid because they sort of accomplish some of their Medicaid goals by controlling overall sort of supply.

And I think, also, sort of in terms of home care, the same kinds of things. It's a little less direct, but it's going to be a reality, and I think this goes along with the point that Bruce made. This is a small segment of the Medicare population, so, it's not like the representative

group that we're thinking about, it's people that are duals and disproportionately them, but, also, I think near-poor, and who are less likely to have supplemental and have many fewer resources to think about that they can rely on their own to be able to find sort of care outside of what the public policies have influenced.

MR. BERTKO: Dana, just a very quick comment, if you do get into Part D drugs, as Bruce was suggesting, there are reports of overuse of antipsychotics in nursing homes, and you want to be able to clarify that, just if you go that way.

MS. HANSEN: This is just to amplify and emphasize I think what, Mark, you've summarized in terms of what Arnie and many of us have brought up. So, even my dual eligible kind of theme that I often times carry is really more emblematic of the totality of this. I offer just two observations based on having been with the PACE Program for 25 years.

When we get people who have--and, again, our average age was 82, 83. So dealing with this was always dealing a great deal with dementia, Alzheimer's in some form, but then when you have a psychiatric diagnosis coupled

with the co-morbidity of normal medical conditions, you have a triple component of that kind of cognition issue, the dementia itself, and then the comorbidities of clinical conditions.

This was the most difficult clinically to deal with, so, there's a workforce issue. If we think we have a shortage in psychiatrists or a shortage in geriatricians, we have a real difficult competency in a whole for geri-psych which is representative of this, plus the medical conditions.

So it's a small population, but I imagine this will both grow in numbers and challenge the system both on the state side and certainly the Medicare side as we have more people kind of go over the line into the Medicare Program. So it is one of those areas that, at some point, Mark, to your point, doing it gradually. It is a very complex thing, and it's something that goes over time.

So Bruce your point about thinking about the data that follows people over a period of time is probably a useful, but painful, exercise because when we worked with people in PACE, we followed the last four years of everything, and you could just see these profiles forming

both clinically in terms of the competency that you need, very disruptive, and we would never be able to find access quotes to a bed someplace. This is probably one of those really naughty problems that we can anticipate will cost the program and we just have to figure out how to anticipate managing it.

MR. BUTLER: So, in the materials we got in advance of the meeting, you really did ask the question with regards to which of the scope of what a June Chapter Report looked like, so, I think we're kind of headed towards the broader look in June at a minimum, I think part of your question is do we report on an update payment factor in March with respect to the freestanding IPF, which --

DR. MARK MILLER: This cycle, just in case I wasn't clear on this, were not planning to do an update cycle on IPF this time.

MR. BUTLER: Okay.

DR. MARK MILLER: The notion would be to--I just want to restate this because we're going to be trying to get smart on this, and we're going to be trying to get smart on it from a multiple perspective dimension, and I think I see the June chapter again bringing additional information to

bear on what's happening here, and answering some of these questions about exactly what we're going to bring to bear on these problems is like a lot of things here, we're going to delve into it, we're going to bring information forward, and then we'll have to decide whether we're ready to act.

So, I think our next footprint is kind of June and trying to draw as broad of a picture as we can, and then we'll just make decisions going forward on payment adequacy and the rest of it.

MR. BUTLER: So, I have an observation and a suggestion.

The observation is, to some extent, there's a bimodal population here, and the first is those patients that most people would agree need to be in some kind of institutional setting, and we're not sure which one, and they're pretty significantly ill, and once upon a time, they went to state institutions and they got out of the business largely, and then managed care came in the 90s and said we're not going to pay for that in-patient, particularly for the adolescents, and we've been futzing around ever since still, and which is the right setting?

The second population is more--I hate to call it

garden variety, but the prevalence of depression in aging, it increases, and there's this rapid growth in psychotropic drugs, which once were in the hands of the psychiatrics almost exclusively, and now are routinely prescribed, and appropriately so, by internists, some with a lot of knowledge of what they're doing, some with very little. And those are kind of two different populations, as I look at it, that we should kind of work--I thought, and I could almost envision a panel of people that kind of sit in these various roles and could help bring to life some of this data a little bit better so we're not just looking at the numbers by boxes, but kind of say let me tell you what the world is and the challenges and handoff and we're managing it. It might help appropriately bring light to the issue in a different kind of way than just the analytics.

DR. MARK MILLER: I hope you guys can observe this. It's certainly intended. We definitely try and get past just numbers, and, in this area in particular, since it's going to be so hard to cobble them together, this notion of sort of looking at some of what the states are doing with duals, going out and talking to people is certainly something that we would do because, as I said,

we're trying to figure this out as we go.

So, I think your suggestion is a good one, and also thinking about it from two different population perspectives is something we can carry out.

DR. DEAN: I'd like to follow-up on some of the questions that Jay raised about slide 14, the 29 percent increase. Do we know where those people came from or where they went to? I'm wondering what proportion of them are in nursing homes.

This, in my personal experience, is an ongoing problem, you have people with Alzheimer's who get restless and agitated, and a very rushed and overworked nursing home staff says we just can't deal with this, and they're trying to push people with Alzheimer's. These folks simply don't move fast. You have to go slow, have to be calm, and our nursing homes are so pushed and so, in many cases, short-staffed, they can't provide that kind of an environment, and, so, things degenerate and people start hitting each other, and, lo and behold, they end up in an in-patient facility, which is not an appropriate response, it's not effective, it's not the right way to do it, and, yet, given the realities of the environment in many nursing

homes, at least the ones that I work with, even though these are facilities that are trying to do good care, it just is a clash that evolves, and I think results in both some inappropriate decisions.

But the question is: How can we avoid that? And, secondly, it's an area, unfortunately, where coordination of care over a long term should be even more important than it is in a lot of other situations, and, yet, at least in my situation, the coordination of care between different facilities is less effective and less consistent than it is with a lot of other conditions.

So, it's really a problem. It's very frustrating. I don't know what the answer is, but it's something that I deal with on a day-to-day basis. It comes up often, and it's costly and it's costly in terms of just the overall effectiveness of what we do because if we could deal with these things in an appropriate way, I think there certainly are ways to improve care, but--well, I don't know. Like I say, it's a real frustration because I don't think we do it very well right now, and but how you improve it is a real challenge.

MR. HACKBARTH: Karen, the last word. We're

slightly behind schedule.

DR. BORMAN: Just to follow-up Peter's comment a little bit, as I try and think about that dual population and sort of say what's the common feature within each one, it's one that the mental health diagnosis is the principle diagnosis, and for the other group that you described, the "garden variety" people, it is a diagnosis, but probably not the principle diagnosis.

And then the question would be: I would think that within under 65 piece of our Medicare population that perhaps this and ESRD might be the two biggest things. Right? Principal diagnoses, because I'm struck by the number of these people, that these are disproportionately the under-65 piece of the program, but how much of the under-65 piece do they constitute? Are they anywhere near the fraction of the ESRD people?

MS. KELLEY: I don't know how they compare, but your instinct that they're a large portion of the under-65 population is correct, and I can look at how they compare.

DR. BORMAN: As we think about that under-65 population, if 90 percent of it is these people in ESRD, then that tells us something in our thinking about that

group. Just a thought.

MR. HACKBARTH: Well done, Dana, and thank you.

Our next topic is provider consolidation and prices. Anne and Jeff will begin with a presentation and then we'll turn to our guest panel.

MS. MUTTI: This session is intended to update you on trends in how the delivery system is organized, and we're focusing here on consolidation among hospitals and physicians and the effect that consolidation may have on prices. The topic is intended to inform our agendas both on delivery system reform and fiscal discipline, and the way we've structured it today for you is that Jeff and I will give a relatively brief overview and summary of the issue, and then we're lucky to have two national experts who can really illuminate the research and trends for you.

So in culling through the literature, survey, and other data, we find indications that hospitals and physicians are increasingly consolidating and have been since the 1990s. The reasons for consolidation have changed over time to some extent and the rate of consolidation has been uneven, but there is strong evidence that consolidation vigorously continues.

The consolidation or integration -- I tend to use the words interchangeably -- has been both horizontal and vertical, and since we use these terms repeatedly, the next slide is intended to make the distinction as clear as possible at the outset.

So for our purposes today, horizontal integration is when the same type of providers integrate. So we can have consolidation among physicians, and this may be thought of as when physicians come together and form a large single specialty group practice. We can also have horizontal integration with hospitals, and this is where they merge or form multi-hospital systems.

Vertical integration is when you have two different types of providers coming together. Here, it's physicians and hospitals that we're talking about today.

And Jeff will talk in a minute or two about these trends in greater detail and he'll also talk about how consolidation can have characteristics of both horizontal and vertical integration.

But first, we wanted to anchor you on why provider consolidation could raise issues for Medicare, and to understand how this can be, we'll take a moment to trace the

logic. It starts with the premise that provider consolidation can lead to an imbalance in market power in the negotiations between private insurers and providers. When provider consolidation occurs, insurers have fewer options among providers for contracting purposes and this could put these large groups of providers in a position to command higher prices than they would have otherwise been able to.

While Medicare sets prices and does not face this dynamic directly, the private prices that are determined by these market dynamics do affect Medicare in at least a couple of ways. First, it is likely that as prices rise, so do providers' costs. Higher costs, in turn, increase pressure to raise Medicare rates. And to just focus for a moment on the first part of this statement, higher prices can lead to higher costs, you will recall that we reported this effect in this year's March report.

Specifically, the Commission found that hospitals that do not face financial pressure, that is, they have relatively high payments for their non-Medicare patients, have higher costs. We don't have empirical evidence of what these higher costs buy, but presumably they are things like

higher salaries for clinicians and administrators, new technology, expansion of product lines or building new facilities, things that either meet a genuine community need or are reflective of a hospital's desire to garner greater market share. Higher costs can also, in the case of for-profits, be attributable to dividends to stockholders.

The important point here, though, is that these higher costs increase pressure to raise Medicare rates because some will argue that higher rates require a higher payment -- I'm sorry, higher costs require a higher payment.

A second reason Medicare can be affected by higher private prices is that if private sector prices are too much higher than Medicare rates, if the disparity is too great, it is possible that more providers will no longer serve Medicare beneficiaries, creating an access to care problem for our beneficiaries.

Third, we need to be aware of the implications of policy proposals that we have discussed, such as ACOs and bundling with respect to consolidation. For example, if we encourage integration through such policies, are we increasing prices in the private market?

Now, Jeff will talk about trends.

DR. STENSLAND: So to put the literature on hospital mergers into perspective, I thought we should take a look back into the 1980s, and remember, in the 1980s, we started out with a prospective payment system. There was a big drop in the length of stay, so hospitals had some excess capacity and this is one of the rationales for them merging. The mergers in the 1980s and 1990s in often cases were consolidations, where the hospitals combined operations and worked under one license. To the extent that there was excess capacity and duplication of service lines, there is some room for efficiency gains, and some research by Conner and Feldman as well as later studies by Dranove, Town and others have found that there could be some savings to these types of mergers.

However, more recently, integration has taken the form of hospitals consolidation into systems, but largely running independent organizations. There may be some sharing of protocols or administration, but a key factor in this type of integration could be the market power that comes with negotiating as a system. And the literature is fairly consistent here, showing that the market power associated with system negotiations results in increased

prices, and our two guests will talk about that further.

In sum, consolidations of operations might create some benefits, but simply joining systems primarily for joint negotiation appears to increase prices.

And finally, we should note that some hospitals have market power even when there are several competing hospitals in the market. For example, if a hospital is considered a "must have" hospital due to its reputation, amenities, location, or medical staff, it may command higher prices than other hospitals in the market even if we can't discern differences in the quality of the product.

Now, in this slide, I just have two key points. The first point is that employment of physicians has continued to grow despite the much publicized losses that some hospitals have faced on acquisitions. And the second point is I will try to explain why this might be occurring.

If we look back in the 1990s, there was a wave of physician-hospital integration into vertically integrated systems. In some cases, hospitals were employed, but more often, hospitals and physicians created joint contracting entities called physician-hospital organizations, or PHOs. The purpose of PHOs were to deal with the expected oncoming

wave of capitated contracts from insurers, but the wave of capitation never really swept across the country and these PHOs were often dissolved. Back in the 1990s when I would talk to some hospitals about their PHOs, sometimes they would say they formed the PHO but they never even actually had any contracts with insurers and they just let it dissolve.

However, the much stronger form of integration, employment of physicians, has continued to grow, and this may be counterintuitive given the losses that some hospitals faced on physician practice acquisitions, and these losses were often highly publicized. So I think the simplistic version of the story was that hospitals couldn't manage physicians. We often heard it was like herding cats and hospitals just couldn't do it. And there certainly were some hospitals that divested their employment of physicians, but I think the story is much more complicated than that.

Part of the problem from the 1990s was that hospitals simply paid too much for the practices and required too little in productivity, and what we hear is that hospitals have gotten better at acquisitions and at managing physicians. And there's often -- I shouldn't say

it's often not just a hospital acquisition, it's a system acquisition, so you have one common owner of the hospital and the physician practice. It doesn't have to be hospital dominated. It could be physician dominated.

Second, there are several social and financial factors that may have led physicians to be willing to accept a relatively lower salary for working for an integrated organization and may have led hospitals to be able to provide a relatively higher salary when the physicians work in an integrated organization. So kind of the willingness to accept on the part of physicians might be going down and the willingness to pay on the part of hospitals, or the ability to pay, might be going up, and let's talk about some of those reasons.

First, physicians have told us they often want the simplicity of salary, and certainly there are some part-time partners in independent physician practices. But with the increase of physicians working part-time, particularly in primary care, and that desire for a salaried arrangement, it might just be easier to work as a part-time physician for a hospital than a part-time physician in a practice.

Also, physicians often want the malpractice

insurance from the hospital. Some have argued that hospitals that are self-insured can do this more efficiently than the physician who has to purchase the malpractice insurance on the open market. We don't have much empirical evidence on that, but we do hear it.

Also, hospitals need someone to be on call, and we hear this often in our site visits. There is difficulty negotiating these contracts, and this is consistent with the economic literature. When you have difficulty negotiating a contract, rather than set up contracts with the person, you just employ them, and you could imagine why a hospital would want maybe even some specialists on its staff, some interventional cardiologists or the neurosurgeons. It might be easier to employ them than to try to set up your emergency department, then later try to negotiate with them for their on-call service.

And the longstanding reason, of course, is that hospitals want patients and they want those patients admitted to their hospital. They don't want their admitting doctors to start sending their patients to competing hospitals or even the doctor's own hospital, and so that could be a reason for bringing the physicians in-house as

employees.

And now another thing that I think Dr. Ginsburg will talk about is physicians may want to share in a hospital system's market power. Powerful systems of hospitals may be able to negotiate higher rates with private insurers than a small, independent practice could.

And I want to stop for a moment to say that this is different than what you probably would get out of your economic 101 textbook or what we hear about often. People will often ask us, what is the private market price for an intermediate office visit, and we will have to say, well, there is no market price. It depends where you are in the country. Well, what is the price in this market? And I think the answer may be there is no market price, even in a specific market. There may be different markets for each individual provider. So each individual system might be getting a different price. I think our speakers can talk more about that today.

And the idea when insurers pay large systems higher prices than they pay independent practices, this may encourage those independent practices then to join the larger system.

And finally, I would like to say that there is a similar incentive in the Medicare system, because Medicare pays more for hospital-based physician services than for the same physician services in a physician office. This pricing differential also encourages vertical integration.

So if hospitals acquire physician practices and make those practices hospital based, the hospital will receive a fee for the physician's work and a separate fee, or facility fee, for use of the hospital-based facility. And the sum of the two fees that the hospital will get, the physician work fee and the hospital's facility fee, is often considerably larger than the fee an independent physician would get for providing the same service in their office.

So to make this clear, let's say you have a hospital here and right next door is an office building that holds physician offices. And initially, the physician is billing their services to Medicare as an independent practice, and they're going to get this combined fee for their work and for the physician practice office expense. The next thing they do is then they decide to integrate with the hospital. So now they bill it differently to Medicare and they bill for the physician's work plus an office-based

facility fee. And the combination of the new fee, the two new fees that the hospital gets, is going to be larger than the fee that the physician originally got when they billed on their own. So hospitals could use this additional revenue to try to attract physicians into integrating.

So we've talked a little bit about horizontal integration and some of the reasons for that, and we also talked about vertical integration and some of the incentives there that there are for vertical integration. But in this chart, we provide a simplified presentation of the interaction between horizontal integration and vertical integration amongst hospitals and physicians.

In that upper left-hand corner, we have independent physician practices in a market with several competing hospitals. This may be a competitive market because everybody is competing with each other, but it may be difficult to coordinate care because the physicians and the hospitals are not integrated.

As we move to the upper right-hand corner, we have horizontal integration of hospitals, but there's a lack of physician integration with the hospital.

Now, the yellow arrow going downward from the

upper right corner to the lower right-hand corner represents the incentives for physicians to integrate with the hospital system to gain market power, those incentives I just talked about. If they move to that lower right-hand corner, the hospital may have market power to negotiate higher rates for the physicians if they join that system and the physicians and the hospitals are then united in a powerful system. They could provide coordinated care, but they also may be able to get higher prices from private insurers.

In the lower left-hand corner, we have physicians integrated with hospitals, but the integrated systems will often compete with each other. So this idea is you may have System A. It has doctors and a hospital. System B, it has doctors and a hospital. And they both compete with each other in the community. There is no natural incentive for them to go together for two reasons. One might be efficiency and the other one might be market power.

From the efficiency standpoint, you could say if you have a mid-sized city, you might have two systems and both systems have a neonatal intensive care unit. Both systems may even have an air ambulance service. Both systems may have a neurosurgery department, and the market

really may not be large enough to merit two of those -- duplication of those services, and the systems may argue we could gain some efficiencies if we merge, and we saw some of that type of merger in the 1990s and hospitals often argued it was for efficiencies. Sometimes the FTC would challenge and say, no, it is going to create market power. Hospitals usually won those fights and the FTC usually lost.

But the arrow, the point of the arrow there is to show that there is some incentive for those vertically integrated competing systems to join together into a powerful system with more market power.

MS. MUTTI: So what is the effect of this consolidation on prices? Here, we will talk about vertical and horizontal consolidation separately.

The preponderance of the literature is fairly clear that with respect to horizontal consolidation, and the literature is mostly on hospitals merging, that this horizontal consolidation does tend to increase price. One summary of the literature found that the effect ranged between five and 40 percent, with higher estimates more likely to be in markets where two closely-located hospitals joined together.

There is less literature on the effect of physicians horizontally integrating. That is when they are forming, say, a large single specialty group practice. In general, the literature does suggest that part of the motivation in consolidating is to improve negotiating leverage to get higher prices, but we have not found literature which evaluates the effect empirically.

With respect to vertical integration, where different types of providers are coming together, like hospitals and physicians, there is far less literature. From a theoretical perspective, this type of consolidation can have both pro-competitive and anti-competitive effects, and we have Martin Gaynor here and I think he will be able to describe what the reasons for that are.

From market interviews, we know that many do report that one of their motivations for vertically integrating is to gain greater market leverage, and here, one of our other panelists, Paul Ginsburg, will be a good position to discuss this further.

Consolidation's effect on prices must be considered in the context of its impact on quality and its ability to reduce overall providers' costs. So we've taken

a look at this literature, also.

With respect to horizontal integration, on balance, the literature as reviewed in the 2006 RWJ Report finds that hospital mergers do not improve quality and may lead to lower quality. The evidence on costs -- and here we are talking about per unit costs, that is the cost, say, for a hospital say -- the evidence is mixed. Some mergers do squeeze out costs. Others do not. As Jeff said earlier, they are more likely to reduce costs if the merger fully consolidates services.

With vertical integration, there is some research suggesting that it does result in improved quality and lower costs. Integrated delivery systems are more likely to use care management processes and IT to improve the quality of care, and some integrated delivery systems appear to do a better job keeping people out of the hospital, which suggests that their costs over time, or their longitudinal costs, are lower, if not their per unit costs.

Of course, if we find that integration raises prices and in turn premiums, but we also get better quality, a logical question to keep in mind is whether we could have gotten that improved quality without paying the higher

prices.

Another lens to examine whether current prices are related to value or to other factors, such as consolidation or being a must-have hospital, is to look at the variation in prices paid by insurers to providers. The data is not conclusive in itself, but it can raise questions. Limited evidence does suggest wide variations in price for the same procedure within a State, and we have two examples. They both come from the report by the New Jersey Commission on Rationalizing Health Care Resources chaired by Uwe Reinhardt.

As you can see on this chart, we show the variation in prices that a New Jersey insurer pays six different hospitals for three procedures, CABG, appendectomy, and hip replacement. And as you can see in that first CABG column, the insurer pays Hospital A $26,000 and a little bit more. For that same procedure, that insurer pays Hospital F over $45,000. And this same pattern, you can see across both appendectomies and hip replacements, as well.

In California, we see even greater variation among the rates paid to hospitals by one California insurer, and

these rates are wage adjusted. As you can see, the insurer paid Hospital A $33,000 for a CABG stay, and for that same procedure, it paid Hospital E nearly $100,000. And again, the wide variation is evident in the case of appendectomies, as well.

So as we close here, we felt it was important to raise this topic, especially because some of the policies we have been discussing may increase consolidation and we should be mindful of the research on possible effects on private sector prices and ultimately on Medicare spending and access to care for our beneficiaries.

In the very short run, our next step here is to get any clarifying questions you might have for us and then we will hear from Martin Gaynor and Paul Ginsburg.

And I would put a note in for when you do get to the discussion period, where it's not just clarifying questions but broader questions, we're looking for guidance on what additional research you'd like us to bring back to you. A couple of the things that we have thought about is whether you would like more information about the regulatory environment and how that affects consolidation and also consolidation and the trends in insurers, because here we

focus on consolidation of providers and what that drives, and you may have a question about insurers, also. But I'm sure that there are others and we look forward to that.

MR. HACKBARTH: Okay. Well done. Thank you, Anne and Jeff.

What I'm going to suggest is, in order to stay on time, what we'll do is have our guest panel make their presentations and then Anne and Jeff will take those chairs next to the table, and if you have questions about their presentation, we'll handle that all in one question period.

So Anne or Jeff, are you going to introduce our guests?

MS. MUTTI: We have given you detailed bios of both of our panelists, so you can see that they both have extensive experience in this field, so I will just give the briefest of introductions.

Our first panelist will be Martin Gaynor. He is the E.J. Barone Professor of Economics and Health Policy in the Heinz School of Public Policy and Management and the Department of Economics at Carnegie Mellon University.

Paul Ginsburg is our second panelist. He is the President of the Center for Studying Health System Change

and previously was the Executive Director of PPRC, one of MedPAC's predecessors.

So we welcome both of you. Thank you.

DR. GAYNOR: Thank you. Thanks for having me here.

Let me briefly just tell you a little bit, some thoughts on integration, consolidation, and some of what I have to say overlaps with what Anne and Jeff already said, so that will go very quickly. Here's a brief outline: Just a few facts, some thoughts about the impacts of integration, first with regard to hospitals alone, then with regard to physicians, and hospitals. First, I'll talk about efficiencies and then possible sources of harm to competition.

So as Anne and Jeff said, there had been a great deal of provider consolidation in the United States over the last 15 years. A lot of it has been in the form of hospital merger, acquisition, membership in systems, what is referred to as vertical, hospital and physician integration, and there, there's an awful lot of different forms, and to call this integration in some cases really isn't entirely accurate.

Now, with regard to hospitals, there was a big merger wave in the middle of the 1990s, shortly following the failure of the Clinton health reform, and that resulted in well over 900 deals just from 1994 to 2000. Many markets in large urban areas are now dominated by two or three large hospital systems, in some cases only one. It used to be typical there would be six to 12 independent hospital entities. The proportion of hospitals that are members of systems grew from about 40 percent in 1985 to about 60 percent in 2000. And by the early part of this century, about 90 percent of people living in large urban areas, in larger MSAs, faced very, very highly concentrated hospital markets.

Now, that merger wave went up, and not surprisingly, there were a lot of mergers, so it went down, but it has recently ticked up again. Here's a picture. I won't go into this in any detail. Unfortunately, the green is number of hospitals involved in deals, blue are number of deals, and as you can see, I don't have data or I wasn't able to obtain data quickly on the number of deals going. But you can see the uptick, then the downward trend, and then the uptick again more recently. So a tremendous amount

of activity.

Here's membership in hospital systems. Again, you can see this has been growing very substantially.

Now, with regard to hospitals and physicians, there was lots of increase in affiliation between hospital and systems, as Anne and Jeff described very ably. Some forms of those grew very rapidly up until the mid-1990s, then declined and ticked back up, and as they pointed out, physician employment has been growing very rapidly.

This graph basically replicates their graph. There are just a few more lines for IPA, management service organization, and group practice without walls, but the PHO, which is the red line here, and the light blue line, employment, are identical with what Anne and Jeff have.

Now, what about possible impacts? Let me first deal with mergers or system membership or acquisitions at hospitals and hospitals. There are some potential efficiency gains from integration. There may be economies of scale, and then if you put two smaller entities together and make them bigger, well, then there will be benefits from that. It's possible you can eliminate duplication. These things, I think, are well known and have been discussed a

great deal.

Now, it turns out, again, not terribly surprisingly, that these savings only get realized if the facilities really integrate and combine. You have to consolidate services. You have to close some. Ownership integration doesn't mean facility integration, and it turns out that a lot of the mergers, acquisitions, systems membership didn't result in true integration.

So the evidence on whether hospital mergers led to efficiencies is mixed. I think the one thing I would draw from that is that when there is true integration, when facilities are truly integrated, some things are eliminated or moved, located in one place, then there can be some significant cost savings, but only if that's the case, and it doesn't appear that that actually happens in the majority of hospital mergers that we've seen up to this point in time.

Now, what about harm to competition? Well, again, this is fairly straightforward. If there are fewer competitors, less pressure on price, also possibly less pressure on quality. The research evidence on this is very clear with regard to price. If there is consolidation,

there are substantial increases in price. You can have increases of something like five percent, which is not a trivial amount of money on a base price. In markets with very many hospitals, there's one research study that showed five percent increases due to mergers, even in L.A. and Orange Counties, which had more than 120 hospitals. So even in very large markets, you can get this.

Then in markets with a small number of hospitals -- one study looked at San Luis Obispo, also California -- that study showed that there was a merger that could result in increases of over 50 percent, essentially a merger to monopoly. Very, very large price increases. So substantial price increases.

With regard to quality, the evidence there is mixed. The one piece of evidence I think is quite clear is a study that looked at Medicare beneficiaries who had heart attacks, and they found that in areas where there was less competition, mortality rates, carefully risk adjusted mortality rates for Medicare beneficiaries who had heart attacks were substantially higher. Now, does that mean that hospitals that are facing less competition explicitly say, gee, let's go kill some Medicare beneficiaries? Of course

not. It doesn't mean anything like that. But perhaps -- the study is completely silent on this -- perhaps there's not the pressure to do as well, and it does appear, at least from that study, that even for Medicare beneficiaries, quality is compromised, although, of course, there is no direct competition on price.

The rest of the literature is not large. The results are quite mixed. It's not as clear once you step outside of Medicare and look at private markets.

With regard to hospitals and physicians, again, it seems quite clear that there are potential gains from coordination, collaboration, concentrating volume in some facilities, gains from information, assurance of supply, reducing contracting costs. I think all these things are quite evident. They've been discussed a great deal. What we don't have is a tremendous amount of great evidence on whether these things are realized.

But let me move on to the evidence. At this point, the evidence doesn't show a lot of impacts. Now, I think this is very difficult, in part because there's integration and there's integration and then, well, there's integration. People have studied carefully all the

different forms and varieties which hospitals and physicians might affiliate find there's a plethora of these things and various scholars have built typologies. But even within, say, a particular cell on a typology, there's a lot of variation. Exactly what are the financial incentives for physicians? What are the financial incentives for hospitals? What exactly are they coordinating?

So it's difficult to find impacts. It doesn't mean, of course, that these things couldn't be realized, but at least up to this point, there doesn't seem to be a lot of evidence of that.

One thing that does seem at least -- it seems like bundled payment, evidence from the -- I'm blanking on the exact demonstration, but you folks know that better than I -- demonstration project did actually seem to lower costs and improve quality.

So from the literature, we don't find across literature consistent results on the effects of integration. Like I said, I don't think this is terribly surprising because integration is not the same thing in different places at different points in time. The impact seems to depend a great deal on specific integration. Most

integration doesn't really succeed in aligning hospital and physician incentives, and a lot of integration is focused on financial, not clinical, factors.

Now, what about with regards to competition? Now here, the theory is less clear. With regard to hospitals merging with other hospitals, it seems theory is pretty clear that that's going to reduce competition.

With hospitals and physicians integrating, it's not quite so clear. In particular, if both the hospital and the physician markets are competitive, then integration really can't harm competition because there's a lot of competition in both those markets. But if not, then it is possible that integration could harm competition.

So suppose that one hospital integrates with sort of a key set of physicians in the market and other hospitals don't have access to those physicians. Well, that obviously is going to harm competition in the hospital market because one hospital has sewn up all the key folks in town. It may allow firms that were actually competing with each other to now collude. Hospitals may have to compete less strongly head to head, because by integrating with different kinds of physicians or different groups, they're actually now

differentiating themselves a bit and it's not apples to apples, but it's apples to oranges.

If the hospital market is less competitive than the physician market, then doctors might acquire market power by integrating with the hospital, and Anne and Jeff talked about some instances of that. And integration often does seem to be a strategy to increase bargaining power with insurers.

With regard to empirical research evidence, there has not been a lot of research on this topic. There's not a lot of good data on this. The research that's out there doesn't seem to show much impact on treatments, outcomes, costs, or prices -- maybe there's something else that's omitted -- with some of the exceptions that I just described.

On prices, there are a few papers and they show conflicting results. There is some research where the results show that hospital-physician integration increases prices, but then there is some other research that shows that it doesn't have any impact. So we are not in a situation where we do have a lot of direct evidence at this point in time.

Antitrust enforcement, I'll just talk about the hospital-physician area. There's been a lot of antitrust enforcement, hospital mergers, and as Jeff said, the FTC and DOJ did well in the 1980s, did very poorly in the 1990s, and then made a comeback, winning a major case just a couple of years ago.

But with regard to physician-hospital relations, actually, this bullet one -- it shouldn't read there's been a lot. There has been some. And the enforcement agencies often have been concerned about integration and courts have not often found this to be anti-competitive, but that could change. There was a recent case where there was a ruling against a physician-hospital organization that went the opposite direction. Actually, I should correct myself. That's a consent decree, not a court case. So there has been some concern in antitrust circles. We don't have a long track record on this, but generally, the courts have viewed these things as benign as opposed to anti-competitive.

So just to summarize, there's a lot of integration. There is potential for more efficiency and better quality. These potentials, for the most part, seem

to be unrealized, at least based on the evidence we have at this point in time. Hospital consolidation is often anti-competitive. With physician-hospital integration, it is less clear, but there is the potential for anti-competitive effects. Thank you.

DR. GINSBURG: It's really good to be here, back at MedPAC, and see so many members of MedPAC that I know very well.

I've been asked to give a perspective that comes from site visit research, and in a sense, it's usually fairly complementary to quantitative research. We don't just ask people what they think. We have a systematic way of deciding who to interview and to triangulate the responses.

The policy context for this is that greater provider leverage leads to higher insurance premiums, and it's possible that higher prices could even induce a supply response by providers. Another factor in the context is that with all the discussion about accountable care organizations or other mechanisms to promote integration, many are concerned that such initiatives could facilitate greater provider leverage, either by encouraging

consolidation, either legal consolidation with ownership or virtual consolidation, just working together.

So let me say a few things about the institutional context, because it hasn't come up yet explicitly. You know, compared to -- we used to have a world in the 1970s or before where insurers either reimbursed costs or they just paid whatever charges providers set, and with the creation of managed care, this involved probably the most important impact that managed care has had, was the creation of provider networks with contracts between physicians, hospitals, other providers, and managed care health plans.

And the way it's done today is that health plans will negotiate with each hospital or hospital system, and for inpatient care, they use a mixture of per diems, DRGs, discounted charges. DRGs, unfortunately, are not the dominant thing. I think per diems are. Actually, there's a trend for hospital outpatient care towards negotiating based on the Medicare hospital outpatient payment system.

For physicians, use of the Medicare physician fee schedule is almost universal and insurers negotiate or state physician payment rates explicitly as X-percent of Medicare. Now, health plans tend to just publish or communicate a fee

schedule to physicians and physicians decide whether they're willing to contract with the plan on the basis of that fee schedule, but if the practice is larger, they will probably respond to the insurer, no, that is not enough, we need to negotiate a higher rate, and higher rates will be negotiated. So you have the vast majority of small practices in an area all being paid the same by any insurer, but that the practices that are larger will each have separately negotiated rates.

Now, there are large variations in physician rates by community, and if you will bear with me, I'm going to take, I think, a very significant study that GAO did a number of years ago with data from the Federal Employees Health Benefits Program, the PPO plans, of hospital and physician payment rates. And they constructed adjusted price indexes and the adjusted meant that they were adjusting them by input prices, pretty much the same way that Medicare adjusts its hospital payment schedule and physician schedule. But the term index, they were not indexed to Medicare rates. They were indexed to the average that the Federal Employees Health Benefits Association pays. So just keep that in mind, that this is not relevant to

Medicare, although I'm sure these indexes will -- if we translated this into relative to Medicare, it probably would look the same, except the scale would go up or down. Probably, the scale would go up.

So I just grabbed some examples of both high and low. I didn't want to do the extremes. Actually, the highest metropolitan area for hospital prices was asterisk. That was only one hospital in geographic area that had the high prices. GAO didn't report the name of the hospital, I mean, or the area.

But basically, I focus on Milwaukee as one of the very high things because, in fact, the GAO study was requested by a Congressman from Milwaukee who had enough inkling of what was going on to make a good call in asking GAO for the study. New York City is -- this surprised me -- was a very low hospital price index.

I mean, you go over to the physicians, I chose Madison because I saw many Wisconsin MSAs that were up there as far as very high indexes for physicians. I chose Washington, D.C. Many are familiar with that as being a fairly low.

And particularly for the physician price indexes,

because that we get information in our site visits, a very high correlation between the GAO study and the sites that HSC goes to periodically. They just lined up perfectly.

And MedPAC did a study or commissioned a study in 2003 on physician payment rates, and the conclusion was that there was a very strong correlation with the size of the community. The smaller metropolitan areas had higher physician payment rates than the larger ones.

There have been large swings in hospital leverage over time, and MedPAC analyses that were published in your March 2009 report seem to show a peak in hospital leverage in 1992, peak meaning that the ratio of private payment rates to costs was highest, and a trough in 1999, and it continues to be heading upward. This is also consistent with HSC site visit results. Also, MedPAC analysis shows no trends in physician leverage, also consistent. So here is the, from your report, the hospital charts showing this, what appears to be a cycle, although we don't know if it's headed towards peak or going to continue to rise, and the physician trend, which is very difficult to discern any trends.

Now, I'm going to proceed to analyzing what's

behind these, particularly the variation over time. And four factors I want to talk about are provider consolidation, purchaser requirements for broad provider networks, changes in provider capacity in relation to demands, and the last thing which actually I'm just starting to think about is a pretty substantial variation cross-sectionally -- that's why it doesn't belong on this slide -- in Medicaid payment rates in relation to costs or in relation to Medicare.

I'm going to focus on California for some reasons that may or may not be correct, and then the real reason is at the bottom. It seemed as though trends in leverage in California have been more visible than in other areas, perhaps because it's such a large State, perhaps because the markets are so distinct. Perhaps the swings have been of greater amplitude. But the changes in leverage also seem to apply to physicians as well as hospitals.

California includes many of the prototypes for accountable care organizations. It has medical groups and IPAs that accept capitated risk from insurers. There are hospital foundations. What is a hospital foundation? Well, this is how you get around a prohibition against hospitals

employing physicians. You create foundations that are affiliated, and the foundations employ the physicians, but they work as if the physicians were employed.

But most important is that HSC recently did a site visit study for the California Health Care Foundation which involved in-depth visits to six metropolitan areas in California. Some very interesting differences. We published community reports, or the foundation published them in July, if you'd like to see them. And then we are nearing the end of a series of cross-site analyses. One of them is on hospital and physician leverage. In fact, Bob Berenson, who is a full member of our team for this study, is the lead author with me on the hospital leverage paper. This is another one on the erosion of the delegated model, and we're expecting these papers to be completed soon.

Well, when we asked respondents about market power of providers, frequently, they would volunteer how different it is today than it was -- some respondents said ten years ago, some said 15 years ago -- very striking changes in leverage and little sign that a turning point was coming. They just were seeing continuation of the increasing provider leverage that they were seeing.

One factor is provider networks, and in California, like the rest of the country, the employers and consumers and employees want broad provider networks. In fact, one respondent reported that a benefits consultant did a network disruption analysis, which basically meant that if this employer changed health plans, how many employees would have to change their physician, and the overlap of the networks was 97 to 98 percent. So broad networks.

There have been some recent narrow network products in California, really in response to some of the provider leverage, and CalPERS, which negotiates for all of the State employees and many county and local employees in California, had BlueShield set up an alternative HMO product that excludes the Sutter Health Care System, which has a nationwide reputation for having very high payment rates.

In San Diego, there was a development where one of the major medical groups that was also a hospital system called the Scripps system decided about three or four years ago it was through with contracting with health plans on a capitated basis, that it wanted to be paid fee-for-service. Health plans say this not only made their spending per person in Scripps much higher, but they launched some narrow

network products that excluded the Scripps system, and they have had some reasonable take-up for them.

Hospital and physician capacity is a factor, and there was a perception that in the mid-1990s, in particular, in California there was very substantial excess capacity, both hospitals and physicians, and this certainly undermined the providers' leverage in negotiating with health plans. There's a perception today that the capacity in both hospitals and physicians is very tight. I think some of the factors behind it are there's been rapid population growth in some areas and physician shortages appear most acute in the non-coastal areas. Some respondents say it was because they're not as attractive to live, but also, that's where the more rapid population growth has been, and even if they were as attractive to live, that could be a factor.

I know California has seismic standards that hospitals have a deadline of meeting. I think it's 2014. The standards are stricter along the coast than in the interior. And I think it's likely that those seismic standards, one of the implications has probably shifted some financing capacity in hospitals away from expansion towards replacement of facilities that just don't make the

standards.

And also, there may be some lingering effects of plan leverage in the 1990s. A lot of hospitals in California went under in the 1990s when their rates were really low. Perhaps that capacity was rechanneled into other hospitals or maybe some of it left the industry completely.

There is a regulatory issue that I suspect is fairly unique to California but which is relevant. California has a problem of different regulators for HMOs and for many PPOs, or PPO products, and the HMO regulation is very strict and really comes from the era of you've got to do a lot to protect consumers. Particularly make sure they have an adequate provider network. So if a health plan wants to drop a hospital from its provider network because the demanded price is too high, the plan has to go and get permission from the Department of Managed Health Care to do that, and respondents say that it takes forever, that permission is often denied, and that in the interim, the plan is going to have to reimburse full charges. So that is really not an option for HMO plans. It is for PPO plans that don't face that regulation.

There has been substantial horizontal integration in California, both hospitals and medical groups. And now the two largest systems are the Sutter Health, which has 18 hospitals in Northern California, and Catholic Healthcare West, which actually has a total of 33 hospitals, but throughout the State. And with systems, they can negotiate for the entire system, which is going to be a mixture of hospitals that are very important to have in your network and hospitals that you could do without. But if they are in that system, they will benefit from the system-level clout.

One recent development we heard about is that the University of California systems recently began negotiating as a system, and respondents commented to us, wow, what a bureaucratic organization. It took them this long to figure it out --

[Laughter.]

DR. GINSBURG: -- but that they really were doing quite well now negotiating as a system.

Another factor is -- and this is really within any community as to which hospitals or physicians have clout, which is we call it "must have" status. A lot of it is reputation. How important is it when consumers are looking

at a provider network to see that that provider is in the network? Many respondents refer to Cedar Sinai, you know, the hospital to the stars -- it is a very admired tertiary, quadranary care hospital -- has enormous reputation and gets enormous payment rates as a result. One respondent from a hospital that was in central L.A. and didn't have any clout, any "must have" status, said, oh, they must get four times what we get for similar services.

Some hospitals have clout because they are unique offerings of specialized services. For example, if you are a Level 1 trauma center, that's really important. That can generate -- you know, you lose a lot of money because of the uninsured patients, but that gives you more clout in negotiating rates with private insurers. Some hospitals or medical groups have geographic isolation. You have to have them in your network or it'll really be a lousy network. In some cases -- I don't know if we had any examples in California, but I recall some from Miami, where a hospital is the hospital for a particular ethnic group. So for that group, that hospital being in the network is very, very important.

And I've talked about the "must have" status. We

saw many hospitals in different parts of California that did not have that "must have" status and they had much less leverage. They were struggling as far as the payment rates that they could get.

Let me say something about joint hospital-physician negotiation, that hospitals have been successful in California in applying their leverage to rates for the physicians that are affiliated with them, usually through a foundation. And the degree of affiliation between physicians and hospitals appears to be growing rapidly. It's very attractive to physicians, both because it gives them access to higher payment rates -- and I would say that it was clear that small practices in California were getting rates that were less than Medicare and large practices were getting rates substantially above Medicare.

You know, there are many other reasons why it's attractive to physicians. Many hospital respondents told me that they were forming medical groups, particularly in primary care, because new or young physicians want, they call it in the jargon, a salaried platform. Basically, they don't want to be an entrepreneur, run a practice. They want to go and work for someone for a salary. So aside from

leverage or market power, many hospitals are forming physician groups really as a recruiting device.

Now, this, on the one hand, means that a market like California is moving towards greater potential for integration if being in the same organization is turned that way. I don't know that it necessarily will. I think under today's payment incentives, basically the motivation for hospitals to get physicians into their fold is the age-old one of get physicians who will admit patients to the hospital. The motivation for physicians is to get higher payment rates. So it's quite possible that this coming together just leads to really exploiting the current incentives of the fee-for-service system. One of the respondents referred to it as fee-for-service capitalism, and the contrast was in the delegated capitated model, which he thought was the opposite.

There's a trend towards larger medical groups and IPAs. Some of the consolidation, I think, resulted from the low payment rates in the 1990s as well as the opportunities with the delegated model. And I should say, what is the delegated model? This basically is health plans contract with usually physician groups or IPAs at least for their

professional services on a capitated basis and they delegate the responsibility for managing utilization, other functions, to the capitated entity. This has remained in California. It never took off that much in other parts of the country, perhaps because they lack the infrastructure of the large physician organizations to contract with. It's still pretty popular among physicians and health plans in California, although we see a number of factors leading to a very slow erosion of that model.

So I mentioned the higher payment rates. Also, antitrust policy generally limits IPA, Independent Practice Association, negotiation with health plans to when they're negotiating capitated rates as opposed to if it's a -- they can't negotiate a PPO contract with fee-for-service rates, generally. But there are exceptions for IPAs that are clinically integrated, and one of the major ones in San Francisco, called Brown and Toland, was -- very proudly told us that they had been granted this status, that they were FTC and that the Justice Department decided that they were clinically integrated and thus they could negotiate with PPOs as a body.

There have been some moderating influences. It's

not all one side. One of them is concern about higher premiums eroding employer-based coverage. One factor, I think, unique to California is competition with Kaiser Permanente, so that a large hospital system might say, well, if we extract the most we can from insurers, it means that the premiums for non-Kaiser products are going to be higher and ultimately all of the non-Kaiser providers will lose their market share to Kaiser if we push the rate up too high. I suspect given tragedy of the commons, this probably applies only to the very largest hospital systems.

So what's the outlook for the future? I see from -- I can see today a continuation of this trend towards greater provider leverage. Perhaps there will come a point where providers are sated. In a sense, they'll say, rates are high enough and rates will just go on the same trend that costs do.

We do see a demand side response, as I mentioned before, some narrow network products. And also, there are some benefit structures, although they really developed fairly slowly, that incorporate incentives for provider choice.

Which brings us to policy. Certainly, I think

Marty discussed what potential there might be for -- I think there is more vigorous antitrust enforcement today. You know, frankly, I think a lot of this is the cat's out of the bag. I don't see antitrust policy outdoing a lot of the consolidation we have today, although actually, if one was undone, it might really be a deterrent to others as far as their payment rates if they fear that.

You know, it's something where as far as market forces, it really surprised me, and maybe I'm getting to understand it better, how for many years, there's been great resistance about designing benefits structures that actually would translate or provide patients strong incentives to favor providers that work less expensive. I think people don't want that, which says -- and the implication is, well, if there really isn't a market solution, should we start talking about regulatory solutions?

More people these days bring up the Maryland all-payer rate setting system for hospitals. The one comment I want to make about Maryland -- there's a really good paper in the last issue of Health Affairs by the current Director of the Maryland Commission -- is that I think Maryland lasted, whereas all the other hospital rate-setting systems

in the Northeast were abandoned in the 1980s. And I think the reason is the governance, that the Maryland system has governance where it's pretty independent. The Governor appoints the Commissioners. They have long terms. I think they're volunteers. They make the decisions. Their decisions are final. They're open to hearing from hospitals, from the health plans, and other interests.

And I think the difference between the Maryland model, and take what New York did, where it was the health department that was the entity that set the rates and the hospitals just hated it all through, that should the idea be considered again, I think it's going to be really important to focus on the right models of governance for them. Thank you.

MR. HACKBARTH: Marty and Paul, that was terrific. This is a topic that is of particular interest to me. As Paul knows, my first mentor in health care was Clark Havighurst, who was an antitrust professor, so antitrust law was really my introduction to health care.

We will proceed as usual with multiple rounds of questions and comments. The first round is clarifying questions. So could I see hands of Commissioners with

clarifying questions? Peter?

MR. BUTLER: This is for staff. Maybe it's a comment. On slide 11, you have the New Jersey insurance numbers, and something doesn't look right to me, because hip replacements, Medicare, for example, pays a lot more than the rates shown here. You can barely get an implant for the $3,000 that is the purported payment for hip replacement. Just as an example, that --

MS. MUTTI: I have a footnote. Do you want me to read the footnote to it? I don't have it there. I have it on the copy that I brought with me. The definition there is the surgical per diem for total hip replacement. Average length of stay, three days.

MR. BUTLER: Oh, so that's just the per diem. Okay.

Secondly, a question is that it's interesting, the Milwaukee market data that shows that hospital index is a lot higher. I'm sitting in Chicago. I'm aware of that, and actually the managed care payments are a lot higher in Milwaukee. I'm not sure of all the reasons. But you would think that -- as we have looked at efficient providers and what happens when they're on financial stress and so forth,

their costs are lower, et cetera, have we looked at it at a market level like that? So somewhere like Milwaukee, you would think that maybe the costs would be higher, in fact, because overall, the market is extracting higher rates from the private side. Have we looked at it that way?

DR. STENSLAND: [Off microphone.] A few years ago, we did that. We looked at efficient providers, kind of more before the efficient provider analysis, we had a financial pressure analysis.

MR. BUTLER: It would be interesting to look at it at the market level, not just at the individual provider level as a --

DR. STENSLAND: And we did it fairly simplistically, looking at the Herfindahl Index, which is a measure of competition in each market, and there was some translation to -- a little bit of a translation from the level of competition in the market to the costs in the market. We don't have the intermediate step of the private insurers' prices, but the idea is when they have more concentration, they can extract higher prices. When they have more revenue, they can have a little higher costs.

I think we did it and it worked out, but it is a

little bit weak in that we're using this model of competition where we're assuming that there's a Medicare price, because we're using this Herfindahl Index. There's like a market price across the whole market. We didn't get down to the level of detail where we could look at the individual providers' prices that they were getting to see how that affects their individual costs. I think that would be probably a more useful study, is if we could actually get to that level of detail.

DR. MARK MILLER: Jeff, the other thing I thought you would say is -- and I think I've got this right, if I understand the question -- when we were looking at the fiscal pressure analysis that got published in the March report, there were also a couple of media reports in markets where concentration or things had gone on, and we did take a look just -- not systematically, not scientifically, but looked at a couple of markets and the Medicare costs turned out the way you would have expected, meaning that they were higher in those markets. So there were a couple of things that we looked at just on a spot basis.

DR. STENSLAND: Yes, so that was -- we have our theory. And then there would be certain newspaper articles

that would identify individual hospitals as having lots of market power. So then we looked at those individual hospitals that were identified as having market power, where the newspaper identified their pricing structure, to see what was different about their costs relative to other providers' costs in the same market, and we did see much higher costs in the providers that were identified as having high market power, or as Paul would say, the "must have" hospital in the market.

MR. BUTLER: My question, though, is if you take the overall market, not just the individual players within the market, is there a pattern?

MR. BERTKO: Nice presentation. I'm going to go with a question that kind of is based on Paul's last slide, which is policy options, but address it to the whole panel here. As I see it in a clarification, we certainly have talked about antitrust. Secondly, there's the Maryland example out there. Are there any other decent alternatives that are either around anywhere or talked about in the academic literature on these kinds of things? I mean, on one level, it might be connected to MedPAC analysis and the version of the efficient hospital cost structure as a

triangulation point, but are there any mechanisms that academics have been talking about?

MR. HACKBARTH: Can I just ask that we hold that question for a second, just to see if -- because I think this is going to be a rich conversation. So let's just see if there are other narrow clarifying questions before we delve into the big ones.

DR. BERENSON: I thought Paul gave a brilliant presentation, but I actually have --

[Laughter.]

DR. BERENSON: -- have a question for Marty, who also gave a brilliant presentation. Paul had actually mentioned this exemption that the FTC can grant for clinical integration. In your presentation, you emphasized there's not much literature one way or the other, I think, about the virtues of clinical integration, and yet one of the impacts of the designation is to get market power to drive up prices. What are the agencies thinking they're accomplishing? Do you have the history of that?

DR. GAYNOR: That's a good question, Bob. That goes back a ways. There were some joint statements by Federal Trade Commission, Department of Justice, on health

care, and at the time -- I think this was early on -- there wasn't a lot of evidence. But they wanted to allow medical practices the opportunity to try and integrate to gain efficiency. They didn't want to stand in the way of that. So they did allow these windows. I don't think their intent was at all to allow for increases in market power, and they certainly have come down on medical practices when they thought there were violations of antitrust law.

I believe that the Federal Trade Commission and the Department of Justice are actually working on rewriting these statements, but I don't know any of the details at this point in time. So I think that actually bears into these larger questions of policy.

Does that get at your question?

DR. BERENSON: Yes.

DR. KANE: This is great. I'm enjoying it. And I'm glad to see that Boston is not the only market where there are dominant favored providers that achieve leverage over the insurers.

But just a minor question, Martin. On your slide about harm to competition and quality in this study that says Medicare found substantial increases in heart attack

patient mortality due to consolidation, and I'm just wondering, was that a longitudinal study of the change, or was that a cross-sectional? Was it really due to or was it just sort of looked like it might be associated with?

DR. GAYNOR: Yes, good --

DR. KANE: I'm surprised that it would be due to this --

DR. GAYNOR: Yes. So the authors are Dan Kessler out at Stanford, Mark McClellan who's now at Brookings, and I think they went to -- this was using secondary data, but they went to great pains to try and establish causation and they did have cross-sectional and longitudinal data.

Again, what they did find is areas where the hospital market was more concentrated, either fewer hospitals or sort of bigger market shares in the hands of a few, that the mortality outcomes were worse for Medicare beneficiaries with AMI. And again, this is a black box in a sense. They found this and they did go to great pains to try and establish a causal relation, and I believe it is plausibly statistically causal, but exactly what's happening behind all those things, their study did not address.

DR. MILSTEIN: Has anyone studied the relationship

between either high or rapidly rising commercial payment rates to physicians and the availability, maybe on a one- or two-year lag basis, of new physician relationships to Medicare beneficiaries? I'm thinking about the connection here between this phenomenon, which is obviously painful for anybody paying private insurance premiums. I'm thinking about issues in terms of ripple effects on Medicare beneficiaries and one of the early signals is whether physicians' practices are open to new Medicare beneficiaries -- new patients, new Medicare patients. And so the question is, did anyone ever examine the relationship between either absolutely high or rapidly rising physician prices and whether or not physicians are willing to take ne Medicare beneficiaries?

DR. GAYNOR: I think there's probably better prospects for doing the cross-sectional study than the -- because there, you have a lot of variation. It's really -- well, it's shown in the GAO study. It's really enormous. But I'm not aware of anyone that's studied it. Over time, it would be more challenging, because at least my sense from the site visit work is that there really aren't private insurer payments to small practices in relation to Medicare

has not been changing much, so it wouldn't be -- so the increases would only be for the large practices.

MR. HACKBARTH: Paul, let me ask you about that.

DR. GAYNOR: If I may, just --

MR. HACKBARTH: Oh, sure.

DR. GAYNOR: -- I want to second that. I'm not aware of any research on that, but it would be great. The one -- I can't think of specific studies, but I believe going back a ways, there was work done in that with regard to Medicaid payment, so -- now, Medicaid and Medicare, of course, are not the same program in lots of ways, but at least if we see those patterns with regard to Medicaid, it might make us worry with regard to Medicare. Sorry. Excuse me.

MR. HACKBARTH: Paul, I have a vague recollection, and maybe an incorrect recollection, about some work that you folks did three or four years ago where you looked at the relationship between Medicare and private fees and how they varied across markets, and I thought that part of that was you found no relationship between that and a willingness of physicians to take Medicare beneficiaries.

DR. GINSBURG: Oh, yes. Yes, you're right. I'm

glad you brought that up, that we -- I don't remember the study too well, but I can see that we would have the data to do that.

DR. CHERNEW: A student of mine has a study looking at markets where there's a lot of uninsured patients, which makes it, like, lower, and what does that do for the access for the insured, and actually doesn't find a connection.

MR. GEORGE MILLER: Yes, thank you. This is for staff. On slide 7, you talked about the share of hospitals employing physicians continues to grow and for several reasons. Would any of those reasons -- can you separate the growth into categories, where hospitals have employed ED physicians, hospitalists, internists, neonatologists, and employed physicians because of call pay issues, and what percentage of that growth would be attributable to those factors?

DR. STENSLAND: We didn't provide all the details, but this all comes off the AHA annual survey --

MR. GEORGE MILLER: Right.

DR. STENSLAND: -- and they ask them, do you employ physicians to provide primary and specialty care. So

the idea is that they're trying to take out the kind of folks that they employ -- anesthesiologists or pathologists or people on call, to take that all out of there, and that wouldn't be in that chart.

MR. GEORGE MILLER: But hospitalists would and intensivists for if a primary care physician is staying in his office so that they can take care of those patients in the hospital. That would be included in the number.

DR. STENSLAND: I guess some people might interpret the question as that. I would probably --

MR. GEORGE MILLER: At least, I did.

DR. STENSLAND: I would probably not interpret it that way, but since you're a hospital administrator, you might have been filling out the survey -

[Laughter.]

DR. STENSLAND: -- so maybe that's an indication of what's in there.

MR. GEORGE MILLER: And a follow-up, please, to Nancy's question, very, very briefly. On the same question Nancy asked about the substantial increase in heart attack patient mortality due to consolidation, do you have the demographics? Is that any group? Could you tell if that's

out of a certain census tract or socio-economic or demographic information?

DR. GAYNOR: Yes. I mean, I'm not the author of that study, but the used these national data on Medicare beneficiaries for multiple years, so it did cover the entire country. As far as differential effects on subpopulations, I don't recall the details of the study well enough to answer that.

DR. GINSBURG: I would say the point that Dr. Miller raised shows that it's kind of dicey to rely on a survey of hospitals to track employment of physicians. You know, just one thing I would mention is that in Milwaukee, which I had gone for a different project, we're told by everyone that essentially all of the physicians in Milwaukee are now employed by one of the five hospital systems. So there's a very powerful trend that's gone beyond categories like hospitalists, where you'd expect employment, to areas where traditionally there hasn't been employment.

MR. HACKBARTH: Other clarifying questions?

DR. STENSLAND: I might just clarify my statement to George. People might think that, oh, that growth is just hospitalists, but we also looked at data from the MGMA on

their group practices and they also show an increase in the share of the MGMA group practices that are employed by hospitals as opposed to being independent. So it looks like it's more than just hospitals.

DR. BORMAN: I have a question for each of you. First, Dr. Gaynor, you, I think, said -- and correct me if I'm wrong -- that when integration produced substantial savings to a system, that it stemmed in many cases from the ability to reduce facilities, duplicative facilities, and it really was taking out capacity, if you will, or taking out excess capacity. Did I interpret that part correctly?

DR. GAYNOR: Yes. I think not necessarily reducing overall capacity, but certainly reducing -- combining the facilities in a meaningful way, not just combining ownership.

DR. BORMAN: So instead of having the five neonatal units, you now had one and the others were a Level 2, and instead of having five Level 3s, you had one Level 3 and two Level 2s feeding the Level 3 and some of those kind of things.

DR. GAYNOR: You might be doing exactly the same volume as you were before in two separate facilities, but

you've integrated --

DR. BORMAN: Right. Okay. So have you encountered, or Dr. Ginsburg encountered any activity where there was an analogous physician situation that you actually, by taking out physician excess capacity, that there was actually a reduction of physicians that was driven by this sort of reduction of capacity, that you had too many cardiologists or too many folks in a loss leader kind of area, like trauma, for example?

DR. GAYNOR: I'm not aware of that. I mean, Paul may be able to answer more precisely. I don't -- my sense is not that with physicians, that there is not the same sense of excess capacity that there was in a hospital, say, going back to the 1980s and the 1990s. There probably wasn't the drive for that kind of thing. And by the same token, sort of overall, there hasn't been so much concern about hospital anti-competitive effects in the physician market, with some exceptions.

DR. GINSBURG: Yes. I've never heard any discussion in conjunction with a hospital merger that one of the objectives was to reduce physician capacity. That's all focused on the facilities.

DR. BORMAN: And then my last piece would be, since my life is grounded in graduate medical education, your comments about the expectations of today's entry-level generation of practicing physicians, I think, are right on and even more so and would ask that if as part of any of the integration activities that you've studied or observed, is debt forgiveness or loan repayment transfer any part of what goes on in that -- as an offer to help get the physicians to integrate?

DR. GINSBURG: I can't -- I don't know the answer to that question, but my sense is that unlike the initial wave of hospital acquisition of physician practices, I guess in the early 1990s, which went so badly, my sense is that hospitals are not that overly eager to do anything to get physicians aligned with them. I think it's more -- I think a lot of it is, we have an opportunity to accommodate physicians and help ourselves at the same time, as opposed to we really need these physicians and we're going to forgive their loans to get them.

MR. HACKBARTH: So the impetus this time is coming from the physician side as opposed to the hospital side?

DR. GINSBURG: Yes, I think a lot of it is. I

mean, certainly, there's some hospital impetus. I mean, the hospital impetus is -- it's the longstanding impetus, and this is, I guess, affiliating with them is a more current tool, but yes, I think there's much more physician impetus today by both seeking the salaried environment, but also gaining access to higher payment rates. So you could have a situation where, let's say, physicians are less productive when they're employed by the hospital than in private practice, but if the rates are high enough, it still could be viable for the hospitals and the physicians could wind up with a higher income, despite their lower productivity.

MR. HACKBARTH: Okay. Let's go to round two, and since John has been patient, I'll let him be first, and then Mitra.

MR. BERTKO: Paul, shall I restate the question again, or --

DR. GINSBURG: I think I wrote it down.

MR. BERTKO: Okay. Then I'll let you answer, and then I have a follow-up question.

MR. HACKBARTH: It would be good if you'd restate it.

MR. BERTKO: Okay. So my question was, beyond

antitrust enforcement, the Maryland style all-payer type of thing, are there other methods of looking at contracting and cost control that we should think about, and in particular does the academic world have any thoughts about this that we might -- might bear on further investigation, my comment being that we have a triangulation point on costs from work that MedPAC does looking at the -- certainly on the hospital side at the efficient hospitals and knowing what the cost structure would be.

DR. GINSBURG: Yes. Let me begin. Actually, your question motivated me to want to go in somewhat more detail about what are the options on the demand side, and I can begin with two.

You know, there was a response, maybe going back about almost ten years, to create tiered networks for hospitals, and the notion was that there be incentives to patients or enrollees to favor the hospital that the insurer had negotiated a better price, and, of course, the quality was thrown in, too, you know, the ones with better quality and a lower price. And for the most part, the hospitals with leverage were able to defeat them by simply saying, either we're in the preferred tier or we're not in your

network. So tiered hospital networks never really got off the ground.

Now, the physician version, which is called high performance networks, you know, that is in effect, where basically, usually on a specialty basis, private health plans measure the cost per episode of different physicians or physician groups and with whatever claims data they have measure quality, but it has not -- I don't think it's gotten very far, and pushback from physicians is not the problem. You know, the incentives -- most employers have just used that information for information's sake. It's just on the website. A few of them have given very modest incentives in the form of lower cost sharing for employees. Nobody has taken it much further.

The fact that each private insurer went about this on its own has undermined the credibility of the approach, because many physicians see that, oh, I'm preferred for BlueCross and I'm not preferred for Aetna, and it changes from year to year. So a combination of different methods, small sample size, I think, has undermined it.

I think the approach could go further, particularly if there was -- I think Mark McClellan is

experimenting with this -- of getting insurers together to be able to share data and use common measures. But there's still the question of how much are consumers or the public or are employers willing to go down this road.

Theoretically, the ideal demand side approach to this would be reference pricing. Basically, for a particular condition, you look at the lowest contracted price hospital in the area and that's the reference hospital. If people want to go to other hospitals, they pay the difference. I've never seen an example of that in use. So I think that there certainly are potential demand side approaches that I suspect could have some impact.

Now, I think some people would say that certainly the tax status of health insurance, you know, the tax subsidies to health insurance would certainly diminish interest in these demand approaches, and one aspect of health care reform that I can't predict is whether -- well, now it's not limit on the exclusion of employer contributions to health insurance, now it's an excise tax for Cadillac health plans -- whether a fairly strong version of that is in the final -- if there is a final -- reform legislation, you know, that could be very relevant to the

potential of these demand side approaches.

MR. BERTKO: So can I do the follow-up question? So one of the things we've been kicking around with some colleagues here, and Dr. Gaynor, I'll aim it at you since you've done antitrust, would be to use some form of binding arbitration in the following sense. We've got buyers that form an oligopoly, mostly large insurers. We've got sometimes monopoly sellers. I currently live in a community with a single hospital that has a stranglehold on it, and I five years lived in Northern Arizona with another single community hospital. Major league sports, baseball in particular, seem to get to binding arbitration on that kind of somewhat relevant basis. Is there a way that you think this could be made, or facilitated to work, or is it just a cul-de-sac that I've been asking about?

DR. GAYNOR: Well, I'm not 100 percent sure. Binding arbitration is used usually where there is one party on each side and they can't come to an agreement. And there are a number of markets that are dominated by, say, a large hospital system and a large insurer. Pittsburgh is certainly one of them, a pox on both of them.

[Laughter.]

DR. GAYNOR: I don't know that binding arbitration would make our lives better in Pittsburgh. They would agree on some set of prices through the arbitration as opposed to some other set of prices, but I don't see that's really the -- I see that as basically being a different division of the profits between these two parties, both with a lot of market power, as opposed to directly addressing the market power. But it could be that I'm not fully following what the thinking is on arbitration here.

MR. BERTKO: Can I ask one more follow-up, and then I'll stop, which is in the -- my understanding of the major league sports binding arbitration, which I toss into this, is each party comes to the point with an offer and then the arbitrator gets to choose between the two, and so it's to your disadvantage to be too far off in one direction or the other because you lose.

I just point out to anybody who has read the Post this morning, the story about the New Jersey hospital and Horizon BlueCross, and they are at odds and the people -- they're trying to send people to the nearest community to the disadvantage of the people. In Arizona, where you have to drive 150 miles to get to the next large hospital, that's

a disadvantage. So this would be a mechanism to try to drive parties together that doesn't quite get to the Maryland version, but is -- I don't know. I'm just putting it out as being something better than the status quo.

DR. GAYNOR: Yes. It's an interesting idea. I guess I'd have to think about it a little bit more.

Let me say a couple other things about policy, though. I fully concur with Paul's point that if some kind of health care reform changes the tax treatment of health insurance, that could have beneficial impacts. We have no way of knowing what'll happen there. But that could really sort of cool the jets of the demand side impetus.

A couple other things to think about. One thing Paul mentioned is the issue about networks and how selective they are. The wind was taken out of managed care sales in large part because the networks included all providers. Well, if all providers know they're going to be in the network, then the managed care entity doesn't have a heck of a lot of bargaining power anymore.

So if there are things that can be done to strengthen the ability to build selective networks -- Paul mentioned this regulation in California I wasn't aware of

that currently is a barrier -- a lot of that, really, though, is based on demand from employers and employees, and if they don't want narrow networks, if employers aren't willing to have plans with narrow networks, then that won't matter.

One last thought is that thinking about providers that are "must have" providers -- Paul's term is a very good one -- this can fall within the realm of antitrust. There's a notion of things that are called essential facilities in antitrust. Usually, it's something like a port, where there's shipping that has to come in. But "must have" providers could have those characteristics, as well. It's designating those kind of providers as central facilities, requiring that they actually contract in a reasonable way with all entities, might be something to think about. And I think this actually is relevant for health reform more generally. Now, how to implement that, I don't know for sure.

MR. HACKBARTH: Although the "must have" providers in this context are often "must have" by virtue of brand name and reputation, as opposed to they have essential facilities that aren't available otherwise.

DR. GAYNOR: Yes, it could be, but there also can be, say, a very -- say a physician practice provides a very specialized kind of care, given the size of the market -- pediatric oncology or something like that, or very high-end academic medical centers. So agreed.

MS. BEHROOZI: Thank you so much for all of these presentations. The question that I wanted to ask, or observation and then question, I think, is about price versus spending. In the paper that Jeff and Anne prepared, on page 18, you talk about how some markets with considerable integration are high-price markets, but then you also talk later about it's not the same markets. But then you talk about MedPAC's review of Dartmouth Atlas data showing that there are the four, I guess, best -- the lowest-spending areas are integrated markets also.

I guess I'd like to see what the correlation is, or if there is a correlation between prices and spending in those integrated markets, because really in the end, you can be penny-wise and pound-foolish, right? You can have low prices and end up having multiple hospitalizations or whatever as opposed to paying a higher price for a really successful hospitalization where the person never sees the

inside of a hospital again.

And that's something that I struggle with all the time, because, Dr. Ginsburg, your solution -- potential solutions for the demand side, which is where I sit in my day job, is -- I don't really have the opportunity to use reference pricing for hospitalizations because the members I cover work in all of the hospitals in New York City. So that's our network, all the hospitals in New York City. We negotiate prices with them, but we can't do things that are as aggressive as reference pricing, although we do that very aggressively with pharmaceuticals and certain other things.

So what we're trying to do, recognizing that high prices could still possibly get you good value, is work with one of the very few or maybe the only in New York City institution that could be considered somewhat vertically integrated on sort of a bonus system, a gain sharing system, where we're taking a target population and setting a target spend based on historical spend and hopefully seeing them coming in under the target, regardless of the prices, but the total spend comes in lower, and then figuring out a way to split that, to share that gain, and so sort of turning them into an accountable care organization or letting them

behave like one should they choose, of course, monitoring for quality all along the way.

So I just wonder if you have seen examples of that or what you think about that.

DR. GINSBURG: Well, actually, as you were talking, I was thinking about sometimes the potential confusion in language. I think at this meeting, the term integration has referred both to clinical integration of care and coordinated care. It's also been used as really a synonym for consolidation. And I think you were talking about the first one --

MS. BEHROOZI: I'm talking about really an institution that employs doctors and maintains a lot of outpatient facilities. Whether they, in fact, coordinate care, we'll, I guess, see in the outcome of this little experiment. But I really meant the financial and employment structure, the consolidation between the facility and its doctors.

DR. GINSBURG: Sure. Well, one perspective that I can offer that I think might be relevant is that in this ongoing debate about health care reform, there have been various phases of pointing to the Mayo Clinic and other

organizations that are highly integrated in a clinical way and the good work they do, and I don't know for sure, but I suspect that those organizations get very high rates from private insurers.

I think that with the payment system we use, it's probably the only way they can survive, because if you think of the fee-for-service payment system, these integrated organizations that aren't going to have a lot of readmissions and they're going to do things right the first time and do things efficiently, they're going to get paid a lot less by Medicare, by private insurers. So in a sense, until the payment system changes to be more supportive of that, I'm sure there will be examples of very expensive, as far as rates to private insurers, integrated systems that truly integrate care. And yes, it'll be worth it for those entities, but there will be some other organizations that are practicing in the old way of emphasizing volume that might also get higher rates because of their market power, and for those, we're not doing well by paying them a lot.

MR. KUHN: A quick question. Dr. Gaynor, on one of your slides, you had an interesting chart there that talked about from 1994 to 2000, about 900 deals, I think,

and then you also had a bit of a note that said you're starting to see an uptick on that again. And I'm just curious, both for you and Paul, if you could care to speculate or think about it, what does reform, do you think, drive us in this direction of what we might see over the next decade in terms of potential consolidations or integrations that might occur?

Some of the things that I've been reading on some of the blogs and others that have opined on this have indicated that in order to take full advantage for health care reform, we're going to see this new wave of consolidations as part of the process. Others have opined over the fact that it'll occur out of necessity because of some of the Medicare cuts and how they will differentiate between different types of providers. Some will be so weakened, they're going to need to get a partner in order to survive or they might go out of the marketplace altogether.

So I was curious from what you've seen, what you've heard from others speculating, what do you think we're going to see over the next five to ten years in market trends in this area?

DR. GAYNOR: Maybe Paul can say something more

definitive. I really don't know. There already has been a tremendous amount of consolidation, so in some sense, there may not be -- in the hospital market. There may not be a huge number of opportunities left. A lot of hospitals are now operating very near capacity, much differently than ten, 15 years ago. So it's not entirely clear to me. If there's continued pressure on revenues on hospitals, then we may see some more closures and exits, which would consolidate the industry. I'm not so clear on whether we're likely to see mergers or acquisitions. That's hard for me to say.

DR. GINSBURG: Well, Herb, most of the discussions I've been in about likely consolidation in the future have focused on the big picture payment reforms, the episode payment accountable care organizations, about how they might encourage consolidation. And I think one way of thinking of it is like this. You know, clearly, major changes in payment system will be more effective if it's not just Medicare, but if it's designed so that private insurers can do parallel things with their payment. But, you know, you have a situation today where you could have a bunch of providers that are not -- are not allowed to negotiate with plans jointly, but if the payment system is accountable care

organizations, all of a sudden they can.

So the way private insurers see this, oh, this would be awful. They can come together to negotiate with us. You could even get private insurers deciding, well, we won't pursue that because we can negotiate with them separately with current antitrust rules, but if they come together -- so in a sense, if some major reforms in provider payment move forward, I think it's going to change the whole nature of the discussion about market power, about rate setting entirely.

MR. BUTLER: Two comments and a kind of a question. The first is on the earlier chart that showed the decline in PHOs and the increase in employment, I think you left us with the impression that this was occurring for pricing reasons, or at least maybe that's the most important reason, and I don't think that's true. I think, first, on the PHO decline, it's because of, one, the decline in the accepting capitated payments, and two, not unrelated, at least in our market in Chicago, the FTC has been fairly visible in terms of if you don't have clinical integration, if you are not sharing risk, these things are not legal entities. So they've either directly or indirectly forced

the unwinding of some of the PHOs.

The employment increase, I think it's true that hospitals look to employment to capture business, if you will, the patients and doctors, there's no doubt about that, but I don't think they say, oh, I'm going to do this so I can get higher prices. I think on the doctor's side, they want some financial stability, but they don't principally go to employment because they want to get paid more. They want to eliminate the hassle factor in their office, which has grown to be an enormous part of their expense. They want to practice medicine the way they were trained to practice medicine. And they want also, more lately, the IT solution in a standardized kind of way. So I think there are other factors other than the pricing that are creating this integration that are likely to kind of continue, regardless of the economic issue.

With respect to the -- this is obviously an important issue. I don't know anybody who likes the current emotion, time, money we put into contracting, no matter what side you're on. It's just an enormous amount of energy and money and, frankly, waste in the system. If we could find a better way to do this, I would be all for it.

I look at Chicago, and it's interesting. There are differences, as we pointed out, between where there is market aggregation and leverage due to just pure size versus, call it brand. So in Chicago, the largest hospital has a five percent market share. There are 100 hospitals. The largest has five percent, and the largest system, Advocate, approaches 15 percent. There is one system, North Shore University Health System, which got scrutinized by FTC that has a smaller market share, but it's all in one geography, so that may be an exception where, because of size, they can extract prices.

So I would sit there and say, well, what the heck. So the "must have" is all about brand. We've got five academic medical centers within miles of each other that have the high-end stuff, so you don't need all of us, in a sense. And you have a BlueCross plan with over half of the market share. So you think that they'd be in a position to really exert market power, and they do to a point. They're still -- they go to the employer and they say, you know, they don't say, well, we're going to exclude them and therefore your premium can be X-amount lower.

The employers, you're right, they do say, I want

everybody in and the consumer himself is still shielded from whatever Mike might say the price elasticity is of the -- and we're still in a market where people want to go where they want to go, when they want to go, to see who they want to see, and we have not got skin in the game, or the insurers or the employers or even individuals saying, it's less, it costs less, therefore, I'm going to see it in my own pocketbook. I think that's still at the heart of the problem that we haven't quite gotten to.

MR. HACKBARTH: Can I just pick up on that, and then you can respond to us both. In your presentations, neither of you focused on the growing concentration in the insurance business, which in some ways is equally, if not even more, dramatic. And you would think, well, these powerful consolidated insurers might be able to confront the powerful consolidated providers.

But in order to make that work, you need the ability to say to one of the providers, you're not in the network. And so long as there's not sufficient demand for that product, there's just not the ability of the insurer to say, okay, you won't come down, you're out and I'm going to steer people elsewhere. So you've got to have the cost

conscious demand as part of the formula, and I would agree with Peter, that seems to be a critical missing element.

DR. GINSBURG: Yes. As far as the consolidation of insurers, of course, insurers are intermediaries, so to the degree they have market power, the next question is, where can they exercise it? Is it vis-a-vis the providers or vis-a-vis their customers?

You know, I've never studied this, but my sense from talking to people is that the large group part of the insurance market is pretty competitive. I think it's because it's become a national market. And insurers don't make a lot of money there. They make their money with the small groups and the individuals, where at least market power on the consumer side maybe is more significant.

I think the fact that it's difficult to compare insurance -- it's not a commodity market from the consumer side, and it's really hard to say what it's done on the provider side. Perhaps with small physician practices, whose reimbursement seems very low, perhaps that's had an effect there. And, of course, politically, the major entity that's complaining about that has always been the American Medical Association. I don't think you hear it from the

American Hospital Association because perhaps it's not that much a problem to, at least, many hospitals. I'm sure for some it is.

So I suspect that insurer market power vis-a-vis providers probably is an issue for providers, and in large groups, it probably gets passed on to the employer purchasers, perhaps in small groups, individuals, less so.

DR. GAYNOR: I don’t have a lot to add. I agree with both your statements. Obviously, if employers don't have a demand for products that would lead the beneficiaries, enrollees to be more cost conscious, then insurers are not going to provide them. They will sell what people want to buy.

As far as the insurance market, yes, there is some evidence that there is some concentration. There is some research evidence that premiums on average tend to be higher where markets are more concentrated. One of my Ph.D. students has done some work indicating that hospital prices are lower in more concentrated insurance markets. That is kind of preliminary work. I wouldn't lean too hard on that, but that is at least consistent with the kind of story you were telling.

But, yes, at the end of the day, if folks really just want to have generous insurance policies, then there is not going to be a lot to drive the prices down.

DR. GINSBURG: Actually, one more thing. On the first thing about the clout of an insurer which has broad networks, I remember during the early days of managed care, some of these extreme contrasts between the very substantial market power that fairly small HMOs had because they had a narrow network, as opposed to Blue Cross, which was committed to a broad network, and despite its size really had no clout at all.

Today the situation seems to be that insurers only sell broad network products, and the bigger you are, the better the prices you get. So Blue Cross plans tend to get lower prices, and so in this way -- let me see. I lost my train of thought. Sorry.

DR. SCANLON: Thank you very much. I actually think this is probably one of the most important topics that we could be talking about and that is also the least understood by the public in general and by policymakers as well.

I think it is certainly an example of market

failure, and while there are market failures that I think we can probably ever eliminate in the health care sector, this is one we let get worse by not paying attention. And so there is kind of a question of what we do about it now. And I would like in some respects your reactions from a MedPAC perspective in two areas.

First of all, physicians. There is a risk of working from anecdotal information. I have been on a series of site visits that the National Health Policy Forum has done to look at markets and how they operate, and one of the striking things with respect to physicians in a number of these markets is the growth of single-specialty groups. And we are talking unbelievably dramatic growth in these groups, and motivated principally -- and this is in their words -- by market power and the successful use then of that market power.

And so I guess, you know, I would ask sort of you in terms of your concerns about this phenomenon, and from a MedPAC perspective what I think is that it is not really something that we can necessarily do anything directly about, but we can be warning people about sort of when we talk about consolidation in any report that we do.

The second area is the question of hospitals, and there is mention in our briefing materials and in literature I have seen before about how the number of MSAs that have gone to highly concentrated increased dramatically. But when you look at the starting point, it was already high. And I think it deals with what you called the "must haves," which is that we have got markets that are small enough that you are not going to have a whole set of competing hospitals. I mean, it would actually be very inefficient to have a whole set of competing hospitals. So that we are going to have to deal with, in some ways, natural monopolies, natural oligopolies. And so how you deal with that is a question, I think, that we have to address.

And, Paul, you said that the cat is out of the bag, sort of undoing things is probably impossible, and I have exactly that kind of reaction, though I would ask Marty, you mentioned the FTC's recent win, and I am assuming that you are referring to the Evanston case. And the question is: Is there a remedy there that we can learn from? And that is one part of the question.

But from a MedPAC perspective, again, I think it is this thing we have talked about, which is that costs in

some respects are a function of available revenues, and so how we interpret the costs that we observe is a critical thing, and it plays very much into our update recommendations. And so there is a sense that if we have had this kind of consolidation and we are seeing kind of an impact on prices and ultimately on costs, isn't it important for Medicare to try and hold the line, to try and kind of create some sort of pressure in a sense to keep costs down? And at the same time, because of Medicare's primary obligation of access for beneficiaries, we have to very vigorously monitor that access to beneficiaries.

Thank you.

DR. GINSBURG: I would just add one comment on the first thing you mentioned, Bill, about the single-specialty groups. For many years, when we asked about mergers among single-specialty groups, you know, market power was leverage with insurers.

In recent years, that has become number two. Number one reason for mergers has been get to the scale where it is viable to bring in major services into the practice, to bring CT scans, to bring MRIs into the practices.

Now, this, you know, relates directly to Medicare because it is the Medicare pricing structure that has inadvertently made it so profitable for practices to want to get big enough to capture the facility charge of these services. So I think that that has contributed to the rapid consolidation.

DR. CROSSON: I'd like to thank you both and compliment you both for the presentations. It is so nice to have presentations that enable us to just get into the content very quickly.

Now, to go back to the premise of the discussion, it is the notion that some of the ideas that we have been thinking and writing about in the last couple of years, for example, bundled payments to physicians and hospitals and accountable care organizations, were they to proceed in certain directions could end up with the unintended consequence of actually creating market power and raising costs, just the opposite, at least, of one of the purposes that we had in mind. And I think that is right.

The question sort of is, you know, I think for us if we are going to continue this discussion -- and I think we should -- is: Where is the most fruitful area to go to

look for a solution or a mitigating force, if you will, and to try to integrate that subsequently in the discussions that we have about these topics?

So one of those is the regulatory environment, and I think as I have thought about it from the other point of view, or the point of view Peter was describing earlier, which is what it feels like if you are trying to actually create one of these organizations and clinically integrate, you have not only concerns about FTC regulations, antitrust regulations, but you also have to worry about civil monetary penalties for potentially setting up structures which reduce benefits to the Medicare beneficiaries. You have to worry about certain anti-kickback regulations and self-referral regulations and the like.

So the sense is, I think, if you take all of those together, is there a way to get it right in the regulatory environment, including antitrust regulations, to allow the good stuff to go through or to be made through rebuttable presumptions relatively safe enough to go and proceed with a business plan, and yet construct a regulatory net that screens out the bad stuff or that makes the risks so great to pursue anticompetitive behavior that it is no longer

likely to proceed? Because if it is not going to happen that way, then I think either you go to something like John suggested, which is, you know, baseball arbitration or something innovative like that, or we move along the line to more of an all-payer rate regulation, quasi-utility model, which could be exactly where this ends up.

So my question, finally, is: With respect to that, you know, can we get the regulatory environment right -- and maybe this is mostly directed to Paul because he brought this up -- do you think that if one criteria for, let's say, granting a rebuttable presumption was the payment methodology that was delivered to the delivery system -- so prospective payment, full capitation, versus fee-for-service -- would that create, would that be likely to create enough protection, if you will, or a safer dynamic to make the regulatory approach more practical?

DR. GINSBURG: What you've said strikes somewhat of a chord because, you know, a lot of our regulatory structure, some of the provisions you have outlined, were created decades ago in a fee-for-service environment. And I remember how particularly during the era when managed care was so powerful about how -- you know, just the disconnect

between the managed care environment and many of these regulations, which really had fee-for-service roots. And I actually don't know the degree to which that disconnect constrains the managed care environment. But I think that we are -- I was at a small part in a Mathematica project to -- you know, which was planning -- it was physician value-based payments, and a lot of the emphasis was on accountable care organizations. And we saw very starkly that, you know, there are many regulations that would get in the way of moving in this direction.

You know, so the key thing would be perhaps payment would be the best way to define what would qualify for the safe harbor against regulations that were really intended for an entirely different payment system. And, you know, that might be the way to go.

DR. GAYNOR: One thing that you point out is that there are multiple regulators here. There is not just one single entity, and that is going to require coordination, particularly with the antitrust enforcers. So as I mentioned earlier, they did write these guidelines on health care a number of years ago. I believe they are taking a look at those things now. But Medicare and the FTC and

Antitrust Division of DOJ really do need to coordinate.

Now, having said that, with regard to integration between entities that operate in different markets, like physicians and hospitals, antitrust has generally tended to view those things as benign, as efficient, as competition enhancing. And then the burden of proof is on the plaintiff to show that these things are anticompetitive. In general, that has been the tendency in antitrust.

So with regard to all these kinds of arrangements, I would tend to think that the courts would take a favorable -- again, a neutral to favorable view to start, and that they would have to be proven to be harmful to competition otherwise.

MR. HACKBARTH: We're down to our last 25 minutes here, so if people can be as concise as possible, that would be great.

DR. BERENSON: Bill beat me to it in terms of stating what I think is the importance of this topic for MedPAC. I think this is the sort of elephant in the room in health reform that does not get discussed for various reasons. And I think it is also very specifically relevant to our work with ACOs. I have had a number of conversation

with large-employer purchasers and health plan people who don't want to support any move towards integrated organizations because of this market power issue and would rather deal with siloed individual physicians, perhaps with some bundled payment, but really not permitting these kinds of organizations.

Paul mentioned, you know, what happens with some of the better ACOs and they are efficient, so they ask for more. We have from Health System Change interviews two organizations who would be absolute prototypes of what we are talking about, who acknowledged confidentially that they get 250 percent of Medicare. I mean, we are not talking about 20 percent more. We are talking about 250 of Medicare.

And so I wouldn't blame a plan or a purchaser for saying, "I don't want to be promoting that kind of thing," which means we need to be talking about policy alternatives, I think, pretty actively for our ACO idea to go very far.

At the meeting a couple of months ago that Elliott Fischer, Mark McClellan, Atul Gawande, and Don Berwick put on where they brought together ten communities who were high-performing communities, there were a couple who

actually had engaged the entire community in ways that I thought would be viewed by the antitrust enforcement agencies as sort of naked per se violations of antitrust laws. I asked Elliott, you know, what is the model here? He pointed to one in Asheville, North Carolina, in fact, because of the concern, they actually went to the State and claims they are somehow being supervised by the State.

So my question is, one, I think we should know more about that and any similar models that some of these high-performing communities have adopted to allay concern about what they are doing. And I guess I wanted to ask either Marty or Paul if you know about that.

DR. GAYNOR: I don't know about that specifically with regard to these newer models, but there is something called state action immunity. If the state, just as you said, Bob, takes on the role of supervising these entities, then under certain circumstances -- I'm not a lawyer so I don't understand this exactly -- they are immune from federal antitrust action. Mostly these things have -- not always, but mostly these things have been a sham and a shield from federal antitrust enforcers. It is easier to go to the state and persuade the state to put on some kind of

very light kind of oversight or enforcement that does not amount to much and really then shields them from real scrutiny of the federal enforcers. But not always, and obviously, I am not speaking to this specific instance.

DR. KANE: I'm not going to ask a question because I don't think it needs to be at this stage, but a couple things.

One is I think that we might as a Commission be concerned about the hospitals that are the lowest end of payment in the private sector. Even though they are also very efficient often on the Medicare standard, they are often the ones who are not accumulating capital and will not be able to compete as ACOs because they don't have the capital to create the infrastructure, and they are being blown out of the market by the guys who are being paid 250 percent of Medicare.

So I think maybe what we want to think about is, you know, how financially viable are these lower-end, you know, payment-to-cost ratios of 1.01 instead of 2.50, and think about whether they are really going to be able to join the ACO gold rush when the time finally comes.

The other thing, I think, I have just been through

this conversation because I was on the special commission in Massachusetts on payment reform. And just to let you know what we concluded -- and it was, you know, physicians, hospitals, state people. There is a group of people representing the various providers and insurers in the commission. And, you know, granted, we are only making a recommendation, but we came out recommending that all of our providers should form ACOs, should be paid global payments in varying degrees with certain kinds of risks depending on what they are ready for, and then that there should be a board overseeing it and they should be all-payer regulated, you know, let them negotiate within limits and then have a board set targets for how fast those limits can go up or down.

Now, this may never pass. I mean, everybody is coming out of the woodwork saying it is sophomoric or it is impossible or, you know, it is the government intervening in the private sector again. But the politics are obviously not, you know, consensus around these things.

But I think we really do need to start building public awareness around the possibility that, you know, markets are not working and the winners and the losers

aren't necessarily the ones that you want to have win or lose. You know, it is really related to some brands or some often devious market behavior that has happened over the last 15 years. And I think, you know, there is a real need to educate the public on this.

So I really enjoyed listening to your comments and agree with most of your conclusions, and I actually think I have kind of given up on markets. But I am hoping there is some vestige left of, you know, maybe competitive negotiation that can happen. But I think we really have to get realistic about the limitations of that and the possibility that we will end up only with the high-cost systems and that we will lose the lower-cost systems if this plays out in a continuing competitive, non-regulated way.

DR. GAYNOR: I'm not as pessimistic about markets, I suppose, but I can't help myself. I am an economist. But let me suggest something actually with regard to regulatory oversight that might be worth thinking about, although it is, again, probably well beyond the purview of MedPAC itself.

Something intermediate between a market and an all-payer regulator is a system that is used in the

Netherlands for health insurance markets, where there is the Netherlands Health Care Authority that oversees the health insurance markets -- and health care, for that matter, too. And one of the authorities they have is to intervene if there is a large health insurance fund -- this is a very, very large market share, and they dominate the market -- is to start to doing all kinds of things, asking for information, taking a look at what they are doing, they can set price ceilings, they can effectively regulate their prices.

But they do not regulate the entire market ex ante, so they have this sort of capacity to step in, and they work in concert with the competition authority, the antitrust enforcement authority. The difference is that this regulatory authority can act ex ante. They can be more active; whereas, antitrust enforcers are reactive. Just the nature of the beast.

So there may be intermediate kinds of policies that one could think of if one is very concerned that things are evolving in such a way that we are creating these very large entities that just are not going to compete with one another, maybe for good reasons, maybe because they do have

some benefits.

DR. MILSTEIN: I think probably most of us -- it was actually great to see that option listed, that is, essentially just simply await the providers feeling sated. But I think the $99,000 CABG probably dimmed our enthusiasm for that option.

[Laughter.]

DR. MILSTEIN: Also, I want to say that I think this idea of building -- you know, what about capitation as a solution, I personally, you know, like the direction but would be wary about it just because we know in California and in the Boston market, where Nancy comes from, that you can use provider power just to command, you know, whatever is the capitation equivalent of a $99,000 CABG prices. So it is directionally correct, but it still does not -- you know, it simply become a different means by which monopoly power can be exerted.

And I also think it is fair to say that if this evolution continues -- and there does not seem to be anything, you know, in its way -- I think that it is fair to say that Medicare beneficiaries are likely to face declining access to providers. Why should they deal with Medicare

patients if they can get much better prices on the commercial side?

Then you can also sort of see what has happened based on prior experience at MedPAC. Providers then come back to MedPAC and just say, "Look how much money we are losing on Medicare. You have got to do something about it." So you can sort of see the direction of the dynamics, and they are not going to be favorable either for valuing in the U.S. health care system or in terms of Medicare sustainability. Even though it is happening outside of Medicare, you know, the likely impacts on Medicare are extremely unfavorable.

One of the things that this Commission has frequently raised is whether or not there might be some way that by better harmonizing Medicare as a purchaser with the private sector, that, you know, short of an all-payer commission or a fully regulated system, a better harmonized approach between Medicare and the private sector might be able to begin to reprogram providers away from simply boosting prices through consolidation but, rather, pursuing more value, that is, you know, higher levels of health per dollars spent, both for Medicare and the private sector,

which I think is a happy vision for the public interest.

And so what are your thoughts? I mean, here at this Commission we keep giving lip service to this notion of we need to better harmonize what we do with the private sector. But we have yet to, you know, really implement this in any substantial way within that category, which is obviously midway between regulation and market competition, referring specifically to better harmonizing Medicare and the private sector. What are your views as to what some of the options might be that we might begin to reflect on here?

DR. GINSBURG: Arnie, I see harmonizing and market power as very separate things. Think about physician payments. You know, the private sector and Medicare are completely harmonized -- you know, not because they decided to harmonize, but because private insurers on their own saw merit in using the Medicare structure. And we still have 250 percent of Medicare for the group that Bob mentioned in California.

So, in a sense, I think actually harmonization actually I think would facilitate regulatory approaches, when I think of it, because, you know, in a sense it is -- you know, it would be very easy to have an all-payer system

for physicians. They just say, you know, this is the rate, I mean, this is the conversion factor. And, in fact, you know, as a phase-in or even permanent thing, they could grandfather in the fact that, oh, you know, Medicaid pays less than Medicare. But, in a sense, you know, to me the merit of harmonization is to get the entire delivery system onto the right incentives. But I think that to go the next step, it would facilitate the regulation or maybe even it would facilitate even market forces if there was, again, a common understood payment metric, it might be easier to even design kind of demand-side products that had meaning. You know, because one of the things that has prevented demand-side products is that you want to have meaningful prices. So for hospital care, you don't want to have, you know, prices of individual services. You want prices per episode. So if you are going the accountable care organization or quasi-capitated route, it would just be the price for a year. So, you know, in a sense, it might actually promote both opportunities for regulation and opportunities for the market if you had this harmonization.

And one thing I found in a research project a long time ago is that private insurers don't see themselves

innovating in the payment area because they lack the credibility and they lack the clout of Medicare. So I think their perspective is, yes, you know, as Medicare develops systems that we can use, we would like to use the Medicare system. And I think bringing them into the process would probably be very productive.

DR. GAYNOR: Well, one other area for harmonization -- I don't know how much this is done -- is working with the federal antitrust enforcement agencies. So I don't know the extent CMS or MedPAC works with those folks or consults directly with those folks. Does Medicare have the ability to act as a plaintiff in an antitrust suit? I don't know if that is the case or not. But there undoubtedly have been some mergers of hospitals, of health plans that are deleterious to Medicare beneficiaries. I don't know if legally Medicare has standing in such a case, but I think it's certainly well worth trying to work very closely with the antitrust enforces going forward.

MR. HACKBARTH: We are down to our last ten minutes or so.

MR. GEORGE MILLER: Is that a hint to be brief?

MR. HACKBARTH: Actually, let me make it stronger

than a hint.

MR. GEORGE MILLER: I will try to be brief. Let me mention a couple things.

I think Peter had it exactly correct as far as hospitals employing physicians. In fact, recently most physicians that I have talked with, the issue was a lifestyle change. And, in fact, in the medical schools of about 50 percent of women, when I have talked with them, they clearly tell me they have -- they want to have families. They will not work the hours as their predecessors worked. They will not take call. And so there is a dynamic here of a lifestyle change with newer physicians. They want an employment platform that was talked about.

I also think Bill was correct in talking about ACOs and bundled payments, specifically around the growth of single-specialty groups. In two communities that I was in recently, the gastroenterologist and the cardiologist had strong market clout, that they went to providers to demand increased fees, and they built facilities. They got both the physician component and the facility component of that fee and, quite frankly, in both of those instances took

volume away from the hospital. That is not the issue here, but that was a market dynamic of them.

When I first read the chapter without hearing this presentation -- you all did an excellent job to kind of raise some questions -- I was a little concerned about the hypothesis that integration would lead to higher prices where in the paper there were two examples -- in the chapter, two examples, but there are other examples where it doesn't. I think both of you alluded to that the literature is mixed on that point.

So that led me to agree with my colleague Nancy about that there are going to be winners and losers, and my concern would be rural communities who in some cases provide excellent quality care at low prices, and where they would fall in this mix I would be concerned from a global standpoint. I would certainly like to hear your thoughts on that.

And then, finally, if we are pushing toward ACOs and bundled payments, it seemed that this chapter could be misconstrued, at least in my mind, and counterintuitive to the fact that we have got this issue with consolidation versus trying to push toward the ACOs and bundled payment to

-- you know, where consolidation made some sense. In my mind, there is a little bit of conflict from what I have read in the chapter, although, quite frankly, both of you helped clear some of that up.

DR. CHERNEW: Thank you both very much. I have a few quick points.

The first one is I think this is consistent with evidence that at least we are finding, and some others, that there is not a good correlation between the geographic variation literature in Medicare and the geographic variation in the commercial sector, in part because the prices could be very different. That is just a statement.

The second question is: There's models of competition that can generate close to perfect competition with very few providers, as few as two in some models, and that empirically I can find some cites that have three or four you get close to perfect competition. And there are other models that suggest even with a lot of providers, you cannot get down to perfect competition because people demand the broad network or things like that.

I think I take your message that the sort of standard model of competition is kind of somewhat

continuous, and as you consolidate from Los Angeles versus San Luis Obispo, you do see this sort of smooth aspect of consolidation.

So despite all the going around the table, you characterized the empirical literature as consolidation in the provider market leads to market power, more so when you are getting smaller levels.

DR. GINSBURG: For hospitals.

DR. CHERNEW: For hospitals, and presumably for integrated hospital systems. So if we were talking about ACOs and asked the question, How many would you need in an area to have competition?, the answer would be if you had three, it wouldn't necessarily be very competitive.

DR. GAYNOR: I don't know of any evidence on that. For hospitals, at least in isolated small towns, rural areas, you can get to competition with three or four. At least there is some evidence on that. Clearly, there is -- but even in a crowded market, consolidation can increase prices significantly.

DR. CHERNEW: My last question, and this is --

DR. GINSBURG: Michael, before you -- on that one, sometimes -- you know, defining the market is really hard,

but I think a lot of antitrust energy goes into that. And one of the markets that we have regularly gone to, Indianapolis, had four hospitals. And unlike other markets, each hospital had its own part of town, and it seemed like a monopoly market for many years -- until eventually they all started competing for the same growing suburban areas and it became more competitive.

DR. CHERNEW: My last question was on something that I think was asked, which was -- first of all, I strongly support expanding this into the insurance sector. I think that is crucial. I think from your presentation I would take it that simply having more competition in the insurance market won't lower premiums to where we would want them to go, because the insurers are facing market power in the provider sector. So if you can't get the biggest input price down, if there is a lot of consolidation, which you convinced me there was, there is a limit as to how much insurance competition can deal with that. I think that is right. And if we had monopoly insurers, there would even be a worse situation, because then they would just leverage the input prices and charge more.

I think that is what I would take from your

presentation.

DR. GAYNOR: We weren't asked specifically to address insurance, and I didn't. But two things. Say you have a monopoly provider market, if you have a monopoly insurer, you are going to have higher premiums than if you have many insurers, period, end of story. So there is not, unfortunately, a lot of good empirical research evidence on competition in health insurance markets, but there are a few recent papers by some folks that do seem to show that premiums are higher in more concentrated health insurance markets, not controlling really for what's happening in the provider markets.

DR. CHERNEW: If we think the fundamental problem is in the provider sector, it doesn't sound like insurance market competition could necessarily solve the provider sector problems. It would be a limit as to what it would be.

DR. GAYNOR: Sure, of course.

DR. CHERNEW: Let me just -- the last point I would just add is there used to be a lot of emphasis on integration between the insurers and the providers and having competition sort of at that level, none of which is

discussed, but I think it would be a useful thing to at least --

DR. GINSBURG: I would say I think there is very, very little integration between insurers and providers, and that's because -- and there used to be some. Of course, we have Kaiser Permanente, you know, a very successful example if integration. But, you know, with the backlash against managed care, it seemed as though the health insurance from those integrated organizations became less popular, because people viewed it as, oh, I don't want to be constrained to that delivery system. So I actually think there is a lot of potential there, but it's almost as if it has gone away.

The funny debate about cooperatives in health care reform, and some of the examples pointed to -- the ones I recognized were all integrated, and they were organizations, you know, not doing well in today's market just because they were integrated. And there were no examples that I saw of a cooperative that was just a health insurer.

MR. HACKBARTH: Okay, right on time, almost to the second. How about that? Good Chairman, right? Thank you, Paul and Mary, and Jeff and Anne as well. Great job, very thought-provoking topic, and one I am sure we will be

revisiting.

We will now have our public comment period, and for those of you who are new to this, the ground rules are: Please introduce yourself and your organization first; limit your comments to no more than two minutes; and when the red light comes back on here on my microphone, that will signify the end of your two minutes.

Let me also remind people that you can now go to the medpac.gov website, and you can comment through the website on items on our agenda. And it opens, Jim, say again?

DR. MATHEWS: It opened when we posted the meeting agenda, and we will keep it open for one more week.

MR. HACKBARTH: Okay.

MS. SHANNON-CARLSON: Good afternoon. My name is Eileen Shannon-Carlson. I am with the American Nurses Association, and I am a registered nurse.

A recurring theme from MedPAC is the serious shortage of health care providers to serve the Medicare population. Several Commissioners -- many physicians -- have noted the growing contributions of non-physician Medicare providers. There are literally thousands of

Medicare providers who are not physicians, including nurse practitioners, clinical nurse specialists, psychologists, therapists, and many, many more categories.

There is virtually a kaleidoscope of care provided today, and often non-physician providers fill the gaps when physicians are either unavailable or unwilling to care for Medicare patients. There needs to be a fundamental shift in focus to consistently and thoroughly look at the contributions of non-physician health care providers to reflect the realities of health care delivery today, better serve Medicare patients, and ensure the accuracy of the data.

For example, any discussion on mental health is extremely incomplete without taking into account the care provided by psychologists and other non-physician mental health care providers. And discussions of the anticompetitive effects of health care integration are also incomplete without an examination of the effects on non-physician providers.

Thank you.

MR. COHEN: My name is Rob Cohen, and I'm from Excel Health, and I also have a history with the Maryland

system, which Dr. Ginsburg and many of you discussed. I have a comment which leads to a question.

My comment is that with hospitals I believe additional revenue leads to additional costs and that hospitals charging many hundreds of percent of costs, the national average being over 300 percent, leads to cost shifting, increased revenue, and increased costs.

Therefore, my question is: As a potential intermediate step towards Maryland-style all-pay rate setting to improve market failure, what about having a maximum level of charges or a maximum payment obligation, such as 150 percent of Medicare or some other number well below today's charges, to prevent excessive leverage and cost shifting, which would lead to lower cost? You had asked about other potential policy options, and I wonder if this is one of those options which offers incremental change.

Thank you.

MS. PESCHIN: Hi. My name is Sue Peschin, and I'm Vice President of Public Policy for the Alzheimer's Foundation of America. I want to thank the Commission for examining care issues for Medicare beneficiaries with mental

illness and inpatient psychiatric facilities, and in particular for all your dementia-related comments in the question-and-answer section.

As many as 4.5 million Americans have dementia, and that number will multiply in the coming decades as our population ages. According to several studies, dementia alone or with co-existing depression are in the top list of conditions of those 65 and older admitted to IPFs. However, there is limited data on the reasons for why persons with dementia are being admitted to IPFs. It is difficult to cite a precise cause in a person who may have multiple problems such as delirium or adverse drug reactions. We encourage caution for making conclusions when the data are so unclear.

IPF is an appropriate setting for the individual with dementia when he or she is severely behaviorally disturbed and poses a threat to self or others and when inpatient care would be the least restrictive environment. However, there are two issues AFA would ask the Commission to consider in its review of IPF care.

First, since IPF is a common detour for those with dementia, families often ask how they can assess the quality

of the geriatric psychiatric unit and ensure their loved one will be seen by an actual psychiatrist with geriatric expertise. AFA supports the creation of national guidelines for geriatric psychiatry units, including a geriatric psychiatrist on staff to serve as the clinical director and oversee quality and education in the unit. We recognize the serious shortages in the availability of geriatric specialists and support a national workforce strategy to remedy this deficit.

Second, despite the fact that approximately half of residents in assisted living and nearly two-thirds of residents in nursing homes have some degree of cognitive impairment, there are no national requirements for pre-employment or ongoing training in dementia care. Training would go a long way toward avoiding unnecessary psychiatric hospitalizations.

Thank you for your consideration of our views.

MR. HACKBARTH: Okay, we're adjourned. Thank you.

[Whereupon, at 12:05 p.m., the meeting was adjourned.]