MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
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Washington, D.C.

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9:49 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Welcome to everybody.

As most of you know in the audience, this is the meeting at which we vote on our update recommendations for the various Medicare payment systems, with the recommendations to be included in our report published March 1st.

Much of today's agenda is devoted to those update recommendations. The process of developing recommendations on updates is a difficult one and often a frustrating process for commissioners. The nature of the task is that we're supposed to recommend one number that reflects the appropriate increase in rates for broad groups of providers in very diverse circumstances. It is challenging at best to know what that one right number might be.

Our fundamental mission is to bring as much rigor and analysis and data to that process as we possibly can so that the Congress has the benefit not just of our recommendation on the specific number but also has the benefit of the information behind it.

We have been using essentially the same framework for making those update recommendations for the last five or

six years. As those of you who follow our work closely know, we review a variety of factors in formulating the recommendation. Where the information is available, we look at financial information drawn from cost reports. We look at beneficiary access to care, changes in quality of care to the extent that they can be measured. We look at access to capital. In the case of physicians, where we don't have cost report information, we compare Medicare payment rates to private sector payment rates. So we try to zero in on the most appropriate update, looking at a variety of different types of data.

The framework that we've been using for the last five or six years is, I think, a reasonable one. But I also think it's important for us to regularly review our approach. And so over the course of the next number of months, in preparation for next year's cycle, we will be taking a look at the update framework, the payment adequacy framework, that we use to see if we can improve it or potentially even change it in more fundamental ways.

A key concept in that review, at least from my perspective, is the notion of efficient providers. Those of you who follow us really closely, as I know many of you do,

know that MedPAC's mandate from the Congress is to make recommendations that are adequate to support care in efficient providers. That efficient provider language was added several years ago. And so part of the review that we undertake of the payment adequacy framework will be targeted at that, in particular. Are there ways that we can define efficient provider and operationalize, if you will, that concept for the various payment systems?

Exactly where this discussion will lead, I don't know, but I wanted to let you know that we will be undertaking that work.

So now, to turn to the first of our update presentations and recommendations, John, you're going to lead the way on physicians; correct?

MR. RICHARDSON: Yes. Thank you and good morning everyone.

Today I would like to review the analysis of payment adequacy for physician services that was presented at our last meeting in December, present one new piece of payment adequacy analysis that we did not have ready in December, and then present a draft update recommendation for physician payments in 2009.

First, though, we want to be sure that everyone is up to speed on the changes to Medicare physician payment policy for 2008 that were enacted after our meeting in December. These policy changes were made by the Medicare, Medicaid, and SCHIP Extension Act of 2007 that passed both houses of Congress the week of December 17th and was signed by signed by the President on December 29th.

First, the Act put in place a 0.5 percent increase in the physician fee schedule conversion factor effective from January 1st through June 30th of this year. If this change had not been enacted, the update on January 1 would have been negative 10.1 percent.

The Act also stipulates that future update calculations under the sustainable growth rate, or SGR, formula shall should be affected by the new 2008 update. In practical terms, this means that the new law does not change future fee schedule updates which are currently projected to be negative every year through at least 2016 under the current SGR formula.

The Act also extended two payment policies that were scheduled to expire at the end of 2007, the floor on the geographic practice cost index that effectively

increases payments to areas with relatively lower practice costs such as rural areas, and a provision for a 5 percent bonus payment to physicians practicing in designated physician shortage areas. Both of these extensions are effective through June 30th of this year.

Altogether the three policy changes I just described were scored by the Congressional Budget Office as increasing Medicare spending by a total by of about $3.1 billion in fiscal year 2008.

To offset some of these new costs, the Act eliminated all but a fraction of a capped $1.35 billion fund created under the Tax Relief and Health Care Act of 2006, or TRHCA, to fund either the 2008 conversion factor update or the 2008 physician quality reporting initiative.

As you may recall, the Secretary opted, in the final rule for the 2008 physician fee schedule, to apply this fund in its entirety to PQRI for 2008. In effect, the Congress has overridden that decision by the Secretary and instead applies almost all of the fund to offset the cost of the new 2008 update. This action by the Congress is consistent with the Commission's recommendation last year for the use of these funds.

The Congress did not eliminate PQRI, however. To the contrary, it was extended for another year, through 2009. The difference now is that funding for PQRI bonus payments, which are equal to 1.5 percent of a physician's total allowed charges if he or she meets the program criteria, will come directly out of the Part B Trust Fund without the cap on total spending that was imposed under TRHCA.

Lastly, the 2007 Extension Act sets aside a new pool of funding of about $5 billion to be used for future physician updates. We anticipate that future legislation will further define exactly when and how this new funding would be applied. But the important take away at this point is to be aware of the fund's existence and Congress' stated intent to apply these funds to future physician updates.

I now will review the physician payment adequacy indicators that we considered at our December meeting and present the one indicator that we have since December, specifically one that compares Medicare and private insurers' payment rates.

As you will recall, a central component of our adequacy analysis is a survey of Medicare beneficiaries'

self-reported access to physician services. This slide summarizes the key findings of the 2007 survey, which I presented in more detail in December. The survey was fielded from August through September 2007 and provides the most up-to-date information we have on beneficiaries' access to physician care.

First, the survey found that Medicare beneficiaries who needed to make an appointment for routine care or to treat an illness or injury reported better or equal rights of access to their physicians compared to privately insured individuals aged 50 to 64. Medicare beneficiaries more frequently reported never having to wait for an appointment and less frequently sometimes having to wait and the differences between the two groups were statistically significant.

Second, the survey indicated mixed access results among the subset -- about 10 percent -- of Medicare beneficiaries who looked for a new physician in the preceding year. There was a small not statistically significant increase in the percentage of beneficiaries reporting some difficulty finding a new primary care physician. That percentage went from about 24 percent in

the 2006 survey to about 30 percent in 2007. A greater percentage of individuals in the privately insured group who looked for a new primary care physician reported no problem finding one. And that difference between the privately insured and Medicare beneficiary groups was statistically significant.

Also, fewer beneficiaries who looked for a new specialist reported problems finding one in 2007 compared to 2006, and fewer of them reported problems than similarly situated individuals in the privately insured group.

Taken together the result of our 2007 beneficiary access survey lead us to conclude that, at least from a national perspective, beneficiary access to physician care is good for the vast majority of Medicare beneficiaries but also that pockets of access difficulties do exist, especially for beneficiaries seeking new primary care physicians.

In December, we also reviewed the other payment adequacy indicators that are shown on this slide. Just to briefly review them for you, two surveys of physicians that were conducted in 2006, one fielded by the Commission and one by the National Center for Health Statistics, found that

most physicians are accepting new Medicare patients. The 2006 National Ambulatory Medical Care Survey fielded by NCHS in 2006, found that among physicians for whom Medicare compromised at he least 10 percent of their revenue, about 90 percent of primary care physicians and about 95 percent of specialists reported accepting new Medicare patients. These results were similar to the 2004 and 2005 surveys.

On the supply of physicians billing Medicare for fee schedule services, our analysis of 2006 paid claims data found that the number of individual physicians billing the program continued to keep pace with growth in total Part B enrollment. We also looked at the volume and intensity of services provided in 2006 on a per beneficiary basis and found that that continued to grow in 2006, albeit at a somewhat slower overall rate of growth than in proceeding years.

Lastly, our analysis of ambulatory care quality indicators found that most of them increased or remained stable in 2006 compared to the base period two years earlier.

Our final piece of analysis, which was not ready in time for the December meeting, I'll present now. For

THIS analysis, we compare the national average of physician fees paid by Medicare to those paid by two large national private insurers. Averaged across all services and areas, the 2006 ratio of Medicare rates to private payer rates was 81 percent, which is lower than 83 percent ratio we found in 2005. This means that averaged across all physician services and geographic areas Medicare physician fees were 81 percent of the fee schedule amounts paid by the two large national private insurers represented in our analysis.

We also separately compared Medicare's and the private payer's payment rates just for evaluation and management services and found the ratio for those primary care services was 86 percent in 2006. In 2005 that ratio was 89 percent. So here again we see a small decrease in the ratio between the two years. One possible reason for the lower ratios in 2006 compared to 2005 could be because there was no update for Medicare physician payment rates in 2006 while the private payer physician rates presumably increased, at least a bit.

It is important to remember that all of this analysis is based on national averages of physician payment rates and that the differences between Medicare and private

payers' physician fees may vary substantially from these averages within a particular market area or for a particular service.

Taken altogether then, our payment adequacy analysis indicates that Medicare's current physician payment system from a very high level perspective is reasonably adequate and stable. However, as the Commission has pointed out in past reports to the Congress, the current payment system has several shortcomings that I want to touch on briefly before moving to the update recommendation. We think that these payment policies need to be addressed to reach the Commission's goals of increasing the overall value and efficiency of Medicare services.

This slide presents three major payment policy areas where the Commission has discussed ways to improve the value of physician services purchased by Medicare. First, we have discussed how rapid increases in the volume of some services may be assigned the prices Medicare pays for these services are not as accurate as they should be. In response, we've recommended that Medicare should establish an independent expert panel to identify possibly overvalued services and we have suggested that Medicare could consider

automatically correcting misvalued services.

Second, we have analyzed the rapid growth of new diagnostic and therapeutic services that has taken place with limited or no evidence of the comparative effectiveness of these services against the older services that they are replacing. The Commission has presented its views on the need for an independent entity to sponsor and disseminate research on comparative effectiveness that could inform Medicare's decisions on coverage and payment policy for these services.

And third, we have discussed the extensive body of research that shows wide variation across geographic areas in the levels and growth of the volume and intensity of services delivered to Medicare beneficiaries with no apparent corresponding relationship to the quality of care or outcomes. Recognizing the physician's central role in the health care delivery system and the power of her pen and prescribing pad in allocating health resources, the Commission recommended in 2005 that Medicare should measure and provide confidential feedback to physicians on their health care resource use.

Again, the purpose of this brief overview of these

past recommendations and discussions for improving the value of services is to put the draft recommendation I'm about to discuss in some context.

That draft recommendation is as follows: The Congress should update payments for physician services in 2009 by the projected change in the input prices for physician services less the Commission's expectation for productivity growth. The Congress should also enact legislation requiring CMS to establish a process for measuring and reporting physician resource use on a confidential basis for a period of two years.

Based on our current estimates of input price increases, which is 2.6 percent for 2009, and expected productivity increases, which is 1.5 percent, the resulting 2009 update recommendation is approximately 1.1 percent. Compared to the projected negative 5.0 percent update that would occur under 2009 under current law, the recommended update of 1.1 percent would stabilize the physician payment system while Medicare moves forward to improve the value of physician services it purchases.

In terms of spending implications, the proposed update recommendation would increase Federal spending in

2009 by more than $2 billion and by more than $10 billion over the subsequent five-year period relative to current law. Again, enactment of any positive update, or indeed any update greater than the negative 5 percent update under current law, would increase spending relative to that baseline.

The beneficiary financial implications are that the update recommendation would increase Part B insurance and coinsurance amounts for physician services relative to current law and, of course, providers would see higher Medicare payments relative to current law.

I just want to make a couple of brief comments on the physician resource piece of the recommendation.

We are considering that CMS, at the end of the initial two-year period of confidential feedback, should be prepared to use the physician resource data as collected along with quality of care measures to set payment policy. Realistically, it will take time and perhaps additional administrative resources and programmatic flexibility from the Congress for CMS to develop the operational infrastructure needed and be ready to integrate resource use information into the payment system. We suggest the

proposed two-year period as a reasonable time to balance the need for developing the operational infrastructure and to maintain the sense of urgency for this policy change.

That concludes my remarks. Thank you, and I look forward to your discussion.

MR. HACKBARTH: John, could I ask for a clarification? You said that for 2009 the scheduled reduction is minus 5 percent?

MR. RICHARDSON: Correct.

MR. HACKBARTH: It might be helpful for you to connect that to the minus 10 percent that is much talked about for the current year.

MR. RICHARDSON: Sure. First of all, the minus 10 percent that would have occurred January 1st was avoided by the Congress's action at the end of December to put in place a 0.5 percent update for the first six months of the calendar year 2008. Under current law, assuming no further Congressional action, the physician conversion factor would go down by 10 percent on July 1st of this year.

However, the way that the law was written, the changes in 2008 are not to be taken into consideration when calculating the 2009 update which currently is projected to

be minus 5 percent under current law.

So regardless of whether Congress extends the 2008 update that it enacted from January through June, if it extends that for the entire year, regardless of that or not, the update January 1st, 2009 would be minus 5 percent as opposed to the recommendation here which would be to increase it by about 1.1 percent.

Is that as clear as mud to everyone?

DR. SCANLON: Minus 5 percent from what? From the July 1st conversion factor or the January 1st conversion factor?

MR. RICHARDSON: I believe from the January 1st conversion factor.

MS. BOCCUTI: I think, Glenn, was your original question a little bit about why was he talking about 5 instead of 10? Is that what you were asking? Bob is shaking his head no and you're shaking your head yes.

[Laughter.]

MS. BOCCUTI: I think -- realize that it's a 10 percent from what they got the year before. What's in legislation is about two different things. One is the conversion factor. So that they're already going to have

the 5 percent cut because of the SGR. But recall for 2007 there was also a 5 percent bonus. So that brings the 2008 update down to 10 percent had there been no legislation. Does that help?

MR. HACKBARTH: Yes.

MS. BOCCUTI: I think that's what you were asking.

MR. HACKBARTH: Bob did you have a different question?

DR. REISCHAUER: No.

MR. HACKBARTH: Okay. So could you put up the recommendation? The recommendation is before you.

I started by saying that these update recommendations were all difficult. I think for me personally, the physician is maybe the most difficult of all.

For me what this recommendation would say is that, number one, MedPAC does not think that physician fees ought to be cut as would happen if the SGR were just allowed to run its course. And I think that's a very important message for us to convey to the Congress.

The second message is that we think Congress ought to go further than just freeze the rates, as they have done

sometimes in recent years, and that at least a modest increase in the rates is appropriate.

The third message, and this would not be conveyed through the language of the recommendation but more through the text, is that the issues in physician payment as I see them are not so much about the size of the pool, which is what the update factor addresses, but how the dollars are distributed among different types of professionals in different types of activities. It is there where I have, personally, the greatest concern about the signals that we're sending about what we value in terms of physicians' work.

Beginning at this meeting but potentially culminating in our spring meetings, March/April meetings, we will be considering some potential recommendations on those distributive issues and how we can change the relative values and change payment for particular types of services to send better signals. I think that's very critical work but it is separate from this recommendation.

So those are my thoughts about what the significance of the recommendation is. Let me open it up for discussion. Any questions or comments?

DR. KANE: First, I want to echo your concern about the distributional impacts of the current payment system and the fact that evaluation and management services in particular, we believe, are grossly undervalued and also cannot achieve the kind of productivity that perhaps some of the more technologically advanced specialties get. If we could, I would prefer to split the update into two different parts that had a market basket or input prices for evaluation and management. And then I don't really have a lot to say about the others. But I wouldn't take productivity out of the E&M because we know there's very little productivity opportunity in the face-to-face work that a physician does plus the other hour it takes to do all of the paperwork or even the electronic medical record input it takes to do primary care in an office based face-to-face work.

So it would be nice if we could acknowledge that at least in our discussion since apparently we can't do it -- I'm not sure why we can't do it in our recommendation -- but to acknowledge that in the discussion.

I'll add one more thing. The other concern I have is that the beneficiary survey as to access, it's 2,000

Medicare beneficiaries across the country. When you're asking 2,000 people across the country whether they have any trouble finding a doctor or seeing a doctor, I think you're getting the advantage of a lot of places where there aren't a concentration of Medicare beneficiaries.

The real impact, I think, of the payment problems in Medicare for physicians might be more obvious in markets where there's a higher concentration of Medicare beneficiaries, for instance maybe Arizona or maybe Florida. Because I'm hearing constantly, from the folks I know in Florida -- which include my own parents -- that there is a problem in seeing a doctor or finding a new primary care doctor.

And I'm wondering if there isn't some tipping point where physicians can see that Medicare are available in some markets because they have a lot of private pay patients to offset that versus markets where there's a greater concentration of Medicare beneficiaries. And that shouldn't we be oversampling, instead, the markets where it's more likely that beneficiaries are going to be having access problems?

So right now the survey, just so people understand

what's underneath that, it's 2,000 people nationwide in Medicare that we are surveying. And it's only about 150 of them or less who are looking for a new primary care doctor. That can't possibly gather -- I don't think we're getting a clear picture really of how hard it is for elderly in the markets where they tend to retire and stay to find a new primary care doctor. And I think we really need to oversample those markets or maybe only sample those markets to get a better sense of what happens when the Medicare population is the predominant population.

MR. HACKBARTH: On that latter point, I think that's important. You wouldn't expect access problems to materialize uniformly across the country geographically or materialize uniformly necessarily by specialty. Each of them would have its own dynamics. In fact, I think the access problems probably are more pressing in some areas than others.

Now CMS, in the past, has made some effort to actually target potentially problematic markets and to study them in particular. Mark?

DR. MILLER: I'm sure Cristina and John know this even better than me, but there was this look. And one of

the takeaways -- and we've discussed this in a couple of meetings and perhaps it just hasn't come up recently. But what you find in those markets is that actually those are markets that are growing uniformly. People are retiring there and they are growing demographic areas. You find access problems for lots of people, not just Medicare. Because the infrastructure for the area is trying to catch up to the growth in the population. And so privately insured people have less access to new physicians and Medicare people.

These studies generally haven't found this strong linkage between the payment rate in Medicare and those issues as much as those markets having surges in demographics that the infrastructure has not caught up to.

DR. KANE: Have they been able to do this recently. My sense is the impact of these zero updates is starting to be more telling than it was maybe even three or four years ago. I don't know.

DR. REISCHAUER: I think this is a very important point because we really got into this, and CMS did sort of with the general idea are Medicare folks have a harder time? I think looking over the last few years the answer is no.

But now we should shift to the canary in the coal mine model which is thinking about those areas where the first signs of a problem might appear. You have given one hypothesis about what those areas look like. I would give an alternative one which would be to look at areas where Medicare payment rates are significantly below those of the private sector.

And there's probably three or four other markers that we might use for how we went about oversampling. But it's really catching the first indications that a problem is going to develop. Because by the time we really see it in the data that we've been collecting it's going to be too late. It will take three or four years to react.

MR. EBELER: I think even within the constraints of the survey, I actually think that the data we've seen in table one, using that canary in the coal mine analogy, do show the problem evolving in the place where you would expect it to first occur, which is differentials in primary care physicians accepting Medicare versus other payments. You wouldn't necessarily expected it to show up on getting a visit with my current physician.

But it just strikes me that even within this data

the leading indicator one would expect has turned in a significant way in a warning flag that I think triggers the need to do a lot more work. But I actually think we're seeing the warning even within this current data.

MS. HANSEN: Relative to just -- besides the canary in the coal mine, the other component of fast-growing populations have to do with some states that have really diverse pockets of populations that are growing at greater speed. And that was our chapter on the future beneficiary. There are some pockets that are growing with great diversity, as well. And since some previous studies have shown already some Medicare treatment discrepancies, even with Medicare coverage, it might be just another component to begin to take a look at kind of proactively.

DR. BORMAN: I'd like to remind the group of a comment that Tom Dean made at the last Commission meeting which I thought was a very telling one, that this whole discussion creates such a climate of at best angst and perhaps at the other end outright hostility that it's very difficult for, I think, the provider community to sometimes move past this conversation to taking a bigger picture view of our system and what can be done to make a better system.

I think Tom said that more eloquently than I can.

So this represents, as a practicing physician, a particularly frustrating and painful discussion probably for some of us.

In that context, I believe that Glenn has raised an important point in that this is meant to make a very positive statement that it's not negative 10, it's not zero, that there is something worth rewarding or increasing out there. I would just like to make sure that that is cleanly on the record because I think all of us who go to various physician societies and so forth need to be able to point to that. The physician community really -- it's going to be a hard enough explanation as it is and I think it needs to be very cleanly, strongly stated that this is meant to be a strong differentiation. And I realize the Commission has said on multiple occasions the flaws of the SGR and so forth. But I think that is a very important point.

I think we all agree there may be issues with distribution. I'm not sure I find the issue quite so clean as some of you do about well, it's all wrong on the specialty side and it's all right on the primary care side. I would be happy to anecdotally share with you off-line some

of my personal impressions about that.

I think the whole notion of cognition versus action or perhaps intermediate interventions such as imaging and testing does have a bit more merit. For example, if you were a patient who had a mammographic abnormality and you were sent to me to give you recommendations, I need to consider a spectrum of advice here. I need to consider from doing nothing with no intervention, merely re-examining you, with some sort of intermediate plan of repeated imaging, some sort of minimally invasive tissue approach, or frankly taking it out.

And the right thing for that patient is going to take into the patient's level of comfort, as well. There may be the person that says I want this out regardless of what the evidence may be about it.

So I would like to suggest that there is a level of cognition across all specialties and that a good part of my world is trying to help you decide whether you need the intervention at all. So I would just like to speak to us maybe think about rewarding cognition in all of its forms.

And then finally just a semi-technical comment, which I'm probably wholly unprepared to make, but terms of

the part about measuring and reporting resource use, we talk in the chapter about the volume intensity calculations and so forth. I note the example we used was computer-assisted detection for mammographic services.

I'm a little puzzled and will talk to staff about some of the conversation. This is an add-on code. So that every time you deliver it, you're delivering a primary service with it, that is screening or diagnostic mammography. So that I think you need to regard things like that as a single event because you don't have this CAD in isolation. And the chapter, to me, somewhat suggested that we're substituting CAD for the other service. And really what we're substituting is a higher priced service, basic mammography plus CAD. And I want to be a little bit careful as we go forward about making sure our formulas and processes for measuring and reporting the resources are as accurate as we can make them. They're not going to be perfect out-of-the-box but I think we need to be real careful about that part.

DR. STUART: I'd like to go back to the access to care issue and actually it's a question for John. CMS conducts an annual access to care questionnaire as a part of

the Medicare Current Beneficiary Survey and it's delayed a year from your survey. The 2006 survey I believe is available.

My question is have you gone back -- and it's a much larger sample than you look at and it has more extensive questions. So my question for you is have you gone back and looked at how well the results from your annual surveys tally with what MCBS has come up with?

MR. RICHARDSON: We haven't done that for this year in particular but in past years -- and I'll look at Cristina -- when we've done this in the past they are reasonably consistent. Do you want to add anything to that, Cristina?

MS. BOCCUTI: They are pretty consistent. Of course, it doesn't have the component that our survey has that compares it to the private population. The questions are a little bit different but they're along the same lines.

In fact, even when we did the beneficiary survey -- the MedPAC one -- we tried to make it parallel to MCBS so we could do that for that very reason.

DR. CROSSON: Thank you.

I have some difficulties with the recommendation

and it's in no way a reflection on the work of the staff or the leadership. It's very much along the lines that I think, Glenn, you talked about a few minutes ago.

It seems like the physician payment system is kind of core to a number of the problems that the Medicare program faces, that the country faces for that matter. And specifically in this case, both the issues of long-term Medicare cost trends and the impact of physician decision making, which in very many instances -- as was mentioned earlier -- is reactive to the payment system but also, the relatively rapidly changing impact of the distribution of the payment system and its effect on physician manpower. And that seems to be happening rather more quickly than any of us would have believed it could.

And the fix for that -- since the time to develop, train, and influence new physicians is relatively long -- the fix for that is going to take a significant amount of time. It seems to me that the physician update process, and probably the physician payment system itself, is significantly broken and needs to be fixed.

With respect to the specific recommendation, I have a lot of difficulty understanding, honestly, the

application of productivity, which is an idea derived from industry, to individual physician practice, particularly the practices of physicians involved with cognitive services who have, truthfully, not too many means to increase productivity. In fact, it has become confused, I think, in the marketplace with the idea of adding new office-based services in order to increase productivity as defined by Medicare-billed charges which is, in fact, working against the interests of the program long-term.

And so I have some difficulty with that notion and I actually think it does not belong in a physician update recommendation.

I think what we need long-term is a different approach. I'm glad that we are going to take this on starting at this meeting and hopefully over the next year and see what we can do, see what recommendations we can make both with respect to how physician payment should be updated. But to the extent that it's in the purview of the Commission look over time at the entire basis for how physicians are paid. Because I think in the end that is going to be the key to some of the goals that we have expressed here at the Commission for a number of years and

how to improve the Medicare program.

DR. CASTELLANOS: It's hard to believe that a physician sitting here can say he's slightly optimistic. I think I'm really slightly optimistic because of the conversation we had during the Executive Session where I think we all recognize that there's a significant problem and that the Commission is going to be looking at the payment system or the updates over the next couple of years or next couple of sessions. Hopefully, the payment framework needs to be reevaluated.

Now we all recognize, Glenn, that a plus 1 percent is much better than minus 5 or 10 percent. But it doesn't keep up with our costs. This is still, by the medical community, is going to be looked at as a terrible message. And quite honestly it's insulting.

The medical community has been dealing with the SGR issue as you well know -- and we have potential cut backs through 2016. This six month fix, in my opinion, is a fiasco. Our costs are going up. If you look at CMS's data, it's about 20 percent since 2001. If you look at MGMA data, it's about 40 percent. But the conversion factor is exactly the same as it was back then. So we really haven't had an

increase but our costs are continuing to go up.

I agree with what you said about the productivity. I think, Nick, you've said it. Jack, you've implied it last meeting. Jay, you just said it now. I question whether this is really appropriate for the physician community.

What the update is, as I said, it's really a blunt tool for trying to constrain cost. This blunt tool creates a lot of pressure on the physician societies that have high costs. These are the family practice, general practice, internal medicine, and several specialties. So what are we doing to these people? We are squeezing them even tighter. This is a group that we want to try to protect.

What's happening in the real world? As I said before, we are small businessmen. If we're not in business today, we can't take care of patients tomorrow. And how do we stay in business? We do some things that perhaps are inappropriate. We go into ancillaries to increase our income. Perhaps we do increase volume. I don't think there's any question that happens.

I think what's happened is we're triggering, by our decisions on payment, some of the abnormal or perverse incentives causing us not to respond to some of the core

issues. As you mentioned, Jay, it's so right, the payment really affects a lot of the core issues and the behavior of physicians.

What am I seeing in the real world? I'm seeing doctors go out of business. I'm seeing physicians considering and going into nonparticipating issues. There is a report from CMS -- and it doesn't make sense to me -- but it says that general practice has an 89 percent participating rate.

What is happening in my community? They're going into concierge medicine. They're increasing volume. They're increasing ancillaries. And the AAMC study two years ago showed that perhaps physicians are retiring.

Again, we talked about baby boomers. In the face of baby boomers coming in 2010, we're going to have a significant problem with access. We've seen it in the lay press. Just this past week the Washington Post had a big article about the state of Maryland.

Nancy, you brought up a good point about aging population and different pockets. I live in South Florida. I think it's fair to say, Nancy, you and I had a discussion and your father and mother lived in Naples and they've had a

problem. It's a real problem. It's not something that is okay. I'm seeing this. I really am seeing this. I'm seeing the aging physician in the community.

What's he going to do? He's not going to stay in the practice. It takes eight years to train a physician to replace the physicians that are going out of practice.

I don't think we can sit back and say everything is okay. And I don't think we are saying everything is okay. But this message is still going out to the medical community.

I agree with some of the approaches that we talked about but I can't vote for that. I would strongly say we just need a full update, very similar to some of the other Medicare providers. The hospitals are in the same situation we are. They have increased costs and they have decreased revenue. That's exactly what we're seeing. I think what we're doing is forcing physicians to do some behavioral patterns to stay in business.

DR. WOLTER: Just a few comments. I, too, have a problem with the update, whether it's done using productivity or just 1 percent. I think the SGR, as I've said many times, has become a destructive policy. It's been

very ineffective. It is driving utilization patterns outside of Part B. It has distracted us greatly from focusing on other tactics which might be more effective. I, too, am seeing -- it's noise still -- but I'm hearing a lot about access issues and decisions that physician groups are starting to make about new Medicare patients. I'm worried about that.

One particularly interesting thing, I was on a call with some other group practice leaders recently. There's a group in the Pacific Northwest that won't see private fee-for-service because they're sophisticated enough to know that there's a lot of money being put into that program and yet they're stuck at these fee-for-service rates that don't go up from year to year.

So I think the physician community is really starting to look at themselves as being treated quite differently than the other silos. I'm worried about that because I think, as many of us believe, physician leadership and accountability for cost and quality is going to be an essential ingredient to how we solve a lot of the problems we have. And we've got some policies in place right now that are driving them away rather than bringing them in.

And so I don't think the market basket personally, which is a different point of view update from some of the other Commissioners, is really a very effective lever. I would say that whether it's a zero percent update or a 10 percent positive update, unless we start focusing on some other tactics, we're not going to get control of costs and of quality. And so I really have a hard time with where we are in this update.

And then I did want to comment on the resource utilization because, as I said, I very much believe in physician accountability. There's no question that physicians -- the pen does create a lot of cost. But having said that, it is a trite-ism that has a lot of truth but doesn't tell the whole story. I'm very concerned about a resource utilization approach that would attribute care to a physician who's responsible for 35 percent of the claims and has no control over the other 65 percent. And I would remind us all that Elliott Fisher's work looked at cost of care in both Part A and B. It wasn't just Part B. It was end-of-life care, it was ICU days, in addition to things like days of seeing a specialist in the last two years of life.

So if we don't stop only trying to impose solutions around resource use utilization in silos, we are not going to create incentives for systemness and approaches to care where physicians can become accountable. In my own experience, to tackle complex cost and quality problems takes decision support. It takes data systems. It takes administrative leadership as well as physician leadership. And I'm really worried that we haven't thought through what we might be thinking with this recommendation.

I would also say we don't have much text in here. Are we going to start with high volume/high cost episodes? How are we going to tackle this issue? Design is very important. I'm very, very concerned about the unsophistication, I would say, of where this could go if it is not appropriately designed and instituted.

I would also say that the cost of an episode is an issue, but the issue that none of us have had a good ability to get our arms around is one could reduce congestion heart failure admissions and that way have many fewer episodes that might be looked at. But the episodes of those that remain could be more costly. And so the utilization issue which drives so much cost is sort of the elephant that

nobody has a really good way of getting their arms around. And yet somehow we need to start talking about that as well as unit cost and episode.

I would also say that our experience in the group practice demo is that physicians are very ill-prepared on severity adjustment. The reason for that is in the fee-for-service system you can just circle a given code and your payment will be the same as if you are more sophisticated about any coexisting conditions and that sort of thing. My recollection is that the severity adjuster we're using in that demo comes out of the Medicare Advantage severity adjuster.

In capitation, of course, those systems have become more sophisticated on making sure their coding is more all-inclusive because it's increasingly affecting their reimbursement.

And so how severity adjustment might be looked at as we look at physician resource utilization I think really is challenging. There's many other issues. It's really not worth going into all the potential issues. But hope that we have our eyes wide open about where that part of the recommendation might go.

MR. HACKBARTH: I think, Ron, you said the message was everything is not okay. Before we got too far away from your comment I want to be real clear that I do not think everything is okay. And I don't think that this recommendation should be interpreted by anybody in this room or by the Congress as MedPAC saying oh, everything is okay, just adjust the conversion factor a little bit.

I think that there are a lot of real difficult issues in terms of the impact of the payment system on physicians, in particular particular types of physicians. I think the easy part is to say that. The easy part is to say that it's driving our health care system in the wrong direction. The harder part is to figure out exactly how to change it. We've struggled with that in the past. We've made some recommendations. I think we need to make more. We can make some more come the spring.

I also think it's important to keep in mind that everything is not okay for the beneficiaries that have their cost sharing premiums go up. Everything is not okay for the taxpayers who need to fund the program, many of which are low-income people who don't even have health insurance for themselves and their families. Everything is not okay for

our children. This train is going down the tracks at a pace on a course that I fear for the future of my children.

Everything is not okay. It's not just a matter of saying oh, let's pay more money to all physicians because their updates have not kept pace with input prices. It's way bigger than that.

MR. DURENBERGER: Thank you, Glenn. And thank you especially for making those latter comments.

I think the last time I had opportunity to express something like that relative to this was back in 1989, trying to make an argument for the volume performance standards laid on top of what we were doing with RBRVS, and nobody was satisfied with it. But the argument was always being made that the sight of the gallows gets people to take action that they should.

We've waited for 15, 16, 17 years for a lot of people in physician leadership to take some action. We've not rewarded people who have done it on their own, as Nick and others have expressed. Jay, probably in his own practice. And we have continued to reward those who have not. And so the gallows ain't doing the job. Something else has to do it.

The only thing I want to not let go by here is the issue of productivity. It's really hard for me, and I'm not an economist so I can't tell you what is efficiency, what is effectiveness, what is productivity and things like that. But we all saw the research this week on how many people die because we can't expedite access to cardiac care in this country. In my community several people have done it and they've probably saved hundreds and hundreds of lives but they're not getting rewarded for it because of the fact that the payment system doesn't reward them.

I think I referred in my last little public comments to Atul Gawande's article in basically taking Peter Pronovost's work and saying who in the world is paying for this sort of stuff? Who's is paying for the research? We're sitting around waiting for somebody to raise $5 billion to create a great center of effectiveness research, and at Hopkins this guy is sitting there frustrated as hell because people can't adapt to the notion that he demonstrated in Michigan -- Pronovost I mean -- demonstrated in Michigan. They saved in 18 months whatever it was, 1,500 lives and or something like that and $175 million.

We neither invest in the research or the

researchers. We're largely in practice. They're in Billings or they're at Hopkins or they're in Pittsburgh or they're someplace like that. We're not investing in that, either at the front end to get them to do it, nor are we investing at the back end in paying for those who adopt it. You can look at retail clinics and how they are just chewing away at the productivity issues inside the system. They are producing the kind of care for a lot less money.

So all I would argue for is stop using the national labor department productivity standards as a way to reward Peter Pronovost and people like that -- or penalize them if you will -- and create a health-specific medical-specific definition of productivity, effectiveness. I'm preaching to the choir when I look at you when I say this. But that's the reason why I think keeping a health-specific or medical-specific productivity reward in a payment system is really important.

MR. HACKBARTH: The productivity thing is clearly a difficult one for many commissioners. As I said at the outset, we will do a fundamental look at the payment adequacy approach and, of course that will be an important part of the review.

But for people in the audience who don't follow our deliberations that closely, I just want to be clear about what that productivity adjustment is supposed to do. It is not an estimate of the actual productivity improvement for physicians or for hospitals or skilled nursing facilities or anybody else. It is, rather, an expectation, a policy expectation or a reflection of what I think is a very important part of this reality which is that health care costs are becoming an increasing burden to society.

The taxpayers who fund this program have been increasing their productivity and that's where this number comes from. And the process is often a difficult, harsh, painful, ugly process where people lose their jobs, lose their health benefits, lose their retirement benefits, have their wages held down. It's not easy for them either. There shouldn't be any illusion that oh, we'll have productivity that's magical and clean and happy for the rest of the economy. That's what the taxpayers are experiencing.

And so the idea was to say some of that force, that pressure, ought to be regularly systematically introduced into the Medicare program.

Now it is, as Ron said, a blunt tool, an imperfect

tool. We'll take a look at whether there are ways to do it better. But that is the reason that it's there.

MR. EBELER: A long-term frustration is palpable and I think we all know that. A shorter term question maybe of John.

Nancy raised the idea of a differential update targeted on E&M services because you can't grab primary care physicians. There's no payment mechanism to do that. Do we know roughly how an E&M -- how much of E&M services are provided by primary care physicians versus others? How blunt an instrument is that approach? Is that a knowable fact?

MR. RICHARDSON: Yes.

DR. REISCHAUER: It's not how much of the total. It's of the billing that primary care physicians do, what fraction of it is E&M versus what fraction of the surgeons?

MR. EBELER: You can ask it two ways. It's how much of primary physicians incomes is there. But also if we gave them money for E&M, how much of that money gets to primary care physicians?

MS. THOMAS: There is a chart in your mailing materials in the primary care physician session. It's on

page 26. And it's also going to be in the slide.

MR. EBELER: I knew that. Page 26?

MS. THOMAS: Tab K.

DR. MILLER: Can I make one point on this exchange here?

Late today, at the end of the day, we're going to be discussing the issue of primary care and how to distribute payments or to discuss the distribution of payments within physicians. And this idea is contemplated pretty directly the notion of if you really want to move dollars would you create -- and I won't get into it here -- but a structure in the fee schedule that would identify a particular service provided by a particular type of physician or a physician who may have -- primary care or a physician that has certain types of characteristics, has made changes in their practice that we think are positive, coordinating care, that type of thing.

So this notion is contemplated late in the afternoon, whether you want to link the payment specifically to sets of physicians. There's all kind of issues. One that arises immediately is that the physician can put their specialty on the bill that they send in. There's no rigor

about how the process works.

DR. KANE: [Inaudible.]

MS. BOCCUTI: It's from claims.

DR. MILLER: The specialty is on the claim. It's just that -- that's the word I'm looking for.

MR. HACKBARTH: We need to move ahead.

Before we move to the vote, Tom Dean, one of the Commissioners, has missed this meeting due to illness and it was unavoidable.

He asked that I share a couple of thoughts on the physician update. In fact, let me quote just a couple of sentences from the note that he sent me.

Tom said I support, with some significant recommendations, the recommendation for the physician update. I am sure that a 1 percent update does not adequately compensate for increases in practice costs and there is the real risk of further antagonizing the physician community, many of whom feel they have not been fairly treated by Medicare.

At the same time, I am very concerned about the steadily increasing volume of services and the costs associated with that, as well as the implications all that

has for the long-term viability of the Medicare program.

So that was on the update piece of the recommendation.

And then on the second piece, related to measuring resource use, he simply said I strongly support the second portion of the recommendation.

Actually, let me go on just another sentence or two. He said we need to get the message to the physician community that they -- we, since Tom is a physician -- are the ones in the best position to help revamp the current system and we need more information about our performance.

So those are Tom Dean's comments.

It's time to vote. That's the recommendation. All opposed to the recommendation? All in favor? Any abstentions?

Okay, thank you very much.

Next, we turn to dialysis.

MS. RAY: Good morning. During today's presentation, I'm going to highlight some key information about the adequacy of Medicare's payments for dialysis services. You have seen all this information before, at last month's meeting.

I will present a draft recommendation for you to consider about updating the composite rate for calendar year 2009. This is the last presentation before this analysis will be published in the March 2008 report.

Access to care for most beneficiaries appears to be generally good. There was a net increase in the number of facilities and treatment stations from year to year.

During the past decade, growth in hemodialysis stations has matched growth in the patient population. There's been little change in the mix of patients providers treat. The demographic and clinical characteristics of patients treated by facilities did not change between 2005 and 2006.

With respect to facilities that closed, some of what we found is intuitive. Facilities that closed are more likely to be smaller and less profitable than those that remained open. We see, however, that African-Americans and dual eligibles are overrepresented in facilities that closed compared to those that opened in 2006. The overall access appears to be good for these two patient groups because facility closures are infrequent.

I'd like to reiterate the first point, that there

has been a net increase in the number of facilities and stations from year to year.

We have made a strong statement in the draft chapter that we will keep monitoring patient characteristics for different provider types in the future.

Moving on to changes in the volume of services, first we see that the growth in the number of dialysis treatments has kept pace with the growth in the patient population. The use of dialysis drugs increased between 2004 and 2006 but more slowly than in previous years. The change in drug use is related to the MMA.

As mandated by the MMA, CMS lowered the drug payment rate for most dialysis drugs beginning in 2005. At the same time, the MMA shifted some of the drug profits to the composite rate. So as the drug payment rate fell, CMS increased the payment for the composite rate through the add-on payment. In 2008, the add-on payment is 15.5 percent of the composite rate.

Quality of care is improving for some measures, for example the proportion of patients receiving adequate dialysis and patients with their anemia under control. In addition, more patients are using the recommended type of

vascular access. However, one quality measure, nutritional status, has showed little change over time. Studies have shown that being malnourished increases decreases patients' risk of hospitalization and death. At the end of the chapter we have a discussion of potential ways to improve the quality of nutritional and vascular access care.

We have included in the paper a summary of our discussion for the need to implement pay for performance for outpatient dialysis services. Recall that in our March 2004 report we included a recommendation calling for the Congress to establish a quality incentive program for physicians and facilities that care for dialysis patients. The Commission concluded that the dialysis sector is ready for P4P.

Here is the Medicare margin for both composite rate services and dialysis drugs. It was 5.9 percent in 2006 and we project it will be 2.6 percent in 2008. A couple of points to consider. First, drugs were still profitable in 2006 under Medicare's payment policy for drugs, which was 106 percent of the average sales price.

Second, in addition, part of the drug profit moved to the composite rate in 2006.

Next, providers received an update to the

composite rate in 2006 and 2007 and an update to the add-on payment in 2006, 2007, 2008. I'd like to note here that the recent Medicare legislation did not update the composite rate for 2008 or 2009.

You can see here that the Medicare margin varies but it is positive for the different provider types. It was larger for the largest two chains than for everybody else. This is partly due to differences in dialysis drugs' profitability between these provider groups. Even after holding patient case-mix constant, we find that the two large dialysis organizations have costs per treatment that is significantly lower than other freestanding provider types.

So before moving to our draft recommendation, let me summarize our findings. Most of our indicators of payment adequacy are positive. Our analysis of beneficiary access is generally good, although we will continue to monitor access for specific patient groups, in particular African-Americans and dual eligibles. Provider's capacity is increasing, as evidenced by the growth in dialysis stations. The volume of services, dialysis treatments, and dialysis drugs is increasing, dialysis drugs at a lower rate

than in previous years but quality did not decline for two key measures: dialysis adequacy and anemia status. Providers appear to have sufficient access to capital as evidenced by the growth in the number of facilities and access to private capital for both large and small chains.

This brings us to our draft recommendation, and let me read it. The Congress should update the composite rate by the projected rate of increase in the ESRD market basket index less the adjustment for productivity growth for calendar year 2009. In addition, the Commission reiterates its recommendation that the Congress implement a quality incentive program for physicians and facilities who treat dialysis patients.

CMS's ESRD market basket projects that input prices will increase by 2.5 percent in 2009. Considering the goal for productivity growth, this draft recommendation would update the composite rate by 1 percent in 2009 based on the current market basket forecast. Note that the market basket forecast will change several times before 2009.

Here are the implications of the draft recommendation. On spending, there is no provision in current law for an update to the composite rate. Thus, this

recommendation would increase spending $50 million to $250 million for one year and less than $1 billion over five years. Although beneficiary cost-sharing will increase under this recommendation, we do not anticipate any negative effects on beneficiary access to care. A payment incentive program should improve quality for beneficiaries and result in some providers receiving higher payments or lower payments.

That concludes my presentation.

MR. HACKBARTH: Thank you, Nancy.

As I recall, the chapter also includes language saying that we continue to support bundling for dialysis, doesn't it?

MS. RAY: Yes, it does.

MR. HACKBARTH: The formal recommendation reiterates our belief that we ought to move ahead with P4P. The bundling piece is another important past recommendation of the Commission and I'd like to make sure that that's there in the chapter. It doesn't need to be in bold face, but there in a visible location, prominent location.

Questions, comments for Nancy?

DR. KANE: I might have a small mind, because I'm

looking for consistency here. Why is there no update in the law for ESRD?

And we can see, too, that these are all fairly profitable facilities, particularly the ones that have economies of scale because they're able to purchase drugs apparently on a larger scale -- which suggests one way we can save money.

But anyway, why is it that Congress didn't have an update for ESRD? And why are we offering to give them an update when we have other provider silos that are doing much worse for which we are not being as generous? Is there some rationale? I know, I know, it's a small mind, consistency.

MR. HACKBARTH: Do you want to go ahead?

MS. RAY: No.

MR. HACKBARTH: As for the reason why there's no update for dialysis, I'm not sure that there's a human being that can necessarily answer that question. But there actually -- most providers have written into statute an update. Dialysis does not. Long-term care hospitals is still a different approach. For long-term care hospitals, the Congress gave the Secretary the authority to designate the update.

So there are at least three different approaches across the payment systems and there may be others that I can't remember. So it is not uniform. It is an artifact of legislative history.

As to the last point, you said that there are other providers that are worse off financially who are getting lower updates than dialysis. Who do you have in mind?

DR. KANE: That are legislated to have.

MR. HACKBARTH: Oh, I see.

DR. KANE: Us, no. I'm just wondering if there's some consistently in the legislative mind or is there just some sort of bias against --

MR. HACKBARTH: Okay. Now a question that Nancy-Ann has raised in the past, given this checkerboard approach that exists in legislation, is should we put dialysis on the same footing as say hospitals? Should MedPAC formally recommend that there be an update in law? I think you raised that a couple of years ago.

My reasons, and my reasons alone, for thinking that that wasn't the right thing to do is it seems to me that really, in an ideal world, what you would want to do is

put hospitals and everybody else on the same footing as dialysis.

MS. DePARLE: So I dropped it.

[Laughter.]

MR. HACKBARTH: Just let me say a sentence or two more about my thinking. Particularly for MedPAC, our whole shtick for updates is you look at the data. You look at margins, you look at access, you look at quality, and each year you make a judgment based on the data.

That is inconsistent with saying there ought to be a formulaic increase in the update. By definition, what we do is each year look at the data and see what the circumstances dictate. People could say we do a lousy job of that, but that's our approach.

So it always seemed to me odd for MedPAC to say no, it ought to be done by formula out into the distant future when we think, in fact, it's a judgment call to be made each year.

So those were my reasons to Nancy-Ann. I'm not sure that she was ever persuaded but she gracefully withdrew.

MS. DePARLE: I raised it because I didn't think

it was fair that that one sector didn't have an update in the law. And after Glenn suggested his approach would be to take them away from everyone, I decided that the better part of valor was to leave it to the Congress. And I think the Congress has been considering this issue over the last couple of cycles of looking at Medicare, is whether or not there should be an annual update for dialysis.

DR. KANE: It just seems that it complicates the discussion when the budgetary impacts for the same recommendation are much more negative for some silos than others.

MS. DePARLE: Because it's not in the baseline. You're right, it does complicate our -- you're right.

MR. HACKBARTH: Other questions or comments on dialysis?

DR. MILLER: I guess, for the record, when he said Medicare shtick what he meant was MedPAC's mission.

[Laughter.]

MR. HACKBARTH: Did I really say that?

DR. MILLER: Yes.

MR. HACKBARTH: Anything else? Anything more helpful than that?

Okay, we're going to make up some time here. Thank you, Nancy.

It's time to vote on the recommendation. All opposed to this recommendation? All in favor? Abstentions?

Thank you.

We're going to change gears now with John's help, and talk for a bit about CMS's report on value-based purchasing for hospitals. I'm sure that John will explain what our role is in discussing this report.

John, go ahead.

MR. RICHARDSON: Thank you. Change gears, but not paces.

Good morning, again. In this session I'm going to present a summary of the key features of a report on value-based purchasing for Medicare inpatient services which was submitted to the Congress by HHS and CMS at the end of November in 2007.

The Deficit Reduction Act of 2005, or the DRA, Congress directed CMS to develop and submit a plan for implementing a hospital value-based purchasing program. The DRA also directed the Commission to provide Congress with its comments on the plan, and today's discussion is an

initial opportunity for the staff to get your feedback on the report.

I should note that CMS proposes to implement the hospital VBP program in fiscal year 2009 but the Agency believes that it requires additional Congressional authorization to do this.

In your mailing materials, you received a side-by-side analysis that compares the key features of the CMS report to the Commission's pay for performance principles, so I will touch on those briefly and then get to the key features of the report.

In past reports, since at least 2005, the Commission has articulated four core principles for Medicare pay for performance programs. Specifically, that these programs first should reward providers based on both improvement and attainment relative to performance benchmarks and selected performance measures. That the program should be funded by setting aside a portion of existing payments, which initially should be small -- on the order of 1 to 2 percent -- but increased over time as Medicare gains experience with implementation and more refined performance measures. Third, that the program

should distribute all of the funding that is set aside for performance incentives to the providers that meet the quality criteria. Forth, that the program should have a process for the continual evolution of the performance measures used in the program.

The Commission has also made some specific suggestions with regard to criteria for hospital performance measures which are summarized in you background materials. So in the interest of time I will move on, but I'll be happy to answer questions about those during the discussion.

Now to move on to the key features of the report itself. In the simplest terms, CMS's proposed VBP program for hospitals would work like this. First, Medicare must create a pool of funds that would be available to each hospital based on its performance against specified measures. The report recommends creating this pool for each hospital by withholding a fixed percentage -- initially in the range of 2 to 5 percent -- from each base DRG payment made to the hospital. In the report, CMS presents examples where only the hospital's base operating DRG payments would be affected by this withhold. Medicare payments for capital, disproportionate share hospital, indirect medical

education, and outlier cases would not be affected or adjusted by the withhold.

Then the next question in program design is how Medicare would assess each hospital's performance and ultimately distribute the funds thus created by the withhold. First, to even qualify for the financial incentive, the hospital would have to report on all the performance measures relevant to its service mix. This includes new measures undergoing testing for possible introduction later in the program, measures intended only for public reporting, and of course the measures to be used for determining the financial incentives.

Each hospital would be scored equally on each of the performance measures within three larger groups of measures or domains. Points would be awarded based on the higher of the hospital's attainment relative to national performance benchmarks or based on the improvement in its performance relative to its past performance. In both cases, for both attainment and improvement targets, the hospital would know where its goals are in advance of the performance year.

The measure domains are important because they

introduce the option of weighting different types of measures more or less heavily when calculating the hospital's total performance score. Initially, the three domains CMS contemplates including are processes of clinical care, outcomes, and patient experience. Based on the weights assigned to each domain, Medicare would then calculate a total performance score for each hospital.

In the final step, the hospitals total performance score would be multiplied by a predetermined exchange function to at last get to the percentage of the hospital's incentive pool that it would receive.

The exchange function is simply a mathematical equation that policymakers could adjust to translate a given total performance score into a larger or smaller percentage of the financial incentive pool that would be allocated to a hospital.

The most important take away point for you to get is that once the VBP program is fully phased in it is likely that some hospitals would get back a total incentive payment that is less than the amount in the pool of funds initially withheld and set aside for that particular hospital. That is, it is likely there will be incentive funds left over on

the table after the initial performance-based distribution.

The report goes on to say that these unallocated funds could be distributed in whole or in part as additional quality incentive payments to hospitals but it also contemplates the option of retaining a portion of the unallocated incentive funds as program savings.

CMS does not anticipate there would be any significant unallocated funds in at least the first year of the program where the allocation would be based only on reporting the performance measures, not the actual performance. However, by the third year of the program, when the performance based incentive is fully phased in, it is likely that there would be some unallocated funds by the end of the year.

I just want to touch briefly on performance measures and a couple of other key features of the program and then go on to the discussion. As noted earlier, the performance measures would be organized in three domains which are listed here: clinical process of care, outcomes, and patient experience. A complete list of measures for the first year is included in your mailing materials. I will return to the future of these in just a second.

I also wanted to touch on the data infrastructure and public dissemination of performance results where CMS would build on the processes that it's already developed to implement the current hospital quality data reporting program which has been in place since fiscal year 2005. In particular, CMS believes public reporting of performance results will be a powerful tool along with financial incentives to spur quality improvement by hospitals.

CMS also plans to monitor the program's effects on other aspects of care such as total costs and health disparities to guard against possible unintended consequences.

My last slide gives a glimpse of future of performance measurement under the proposed program. CMS acknowledges the need for measurement to evolve rapidly beyond the current measures set, particularly in the areas of clinical quality, patient-centered care, and efficiency measures. On efficiency measures, CMS indicates that it has concerns about the challenges in developing them and suggests a preference for including both resource use and outcomes when developing efficiency measures.

Lastly, we think it's important to acknowledge the

administrative resource needs that CMS will face in actually implementing and evolving the VBP program if it moves forward. Clearly, this program would be a complex and intricate undertaking for Medicare and it may require due consideration of the resources CMS may need to make its implementation successful.

That concludes my presentation. Thank you.

MR. HACKBARTH: Thanks, John.

So as I understand it Congress, in the same law that mandated this study for CMS, asked MedPAC to comment on the CMS report once it's published, is that correct?

MR. RICHARDSON: That is correct.

MR. HACKBARTH: As I understand it, CMS missed the statutory deadline for their report and so there's not a clear deadline now for MedPAC to report; is that right?

MR. RICHARDSON: That also is correct.

MR. HACKBARTH: My understanding is that there is at least the possibility that in the June Medicare legislation which would address the physician fee issue that Congress may take up some other issues, one of which may be pay for performance. And so there's some eagerness in having our comments on the CMS approach as quickly as

possible. Whether that will work out to be March or April I don't know but we're going to try to move through this. So this is our initial conversation on the report, not the final one.

With the preface, let me just offer a few of my own thoughts on it. I was impressed with the report. Obviously they invested a lot of time and effort in thinking through some fairly complex issues. I won't say that I understand all of it, and I certainly don't understand the implications of all of the choices that they made. But in general, I was struck that it is very consistent in basic principle, very consistent with past MedPAC recommendations on pay for performance.

And I think also consistent with the IOM panel's recommendations on pay for performance.

The two areas where I think there is potentially a significant difference are one, are all of the dollars set aside distributed? CMS, like MedPAC and I believe IOM is saying that the money for the pay for performance program ought to be taken out of the base rates. We said, MedPAC said, it ought to be budget neutral; i.e. all of the dollars taken out of the base rates ought to be redistributed based

on quality. Whereas CMS has left open the possibility that they would not all be distributed. So that's one potentially significant difference.

The second area of difference may be on future measure development and how the program evolves over time. We've not made, in the past, a bold-faced recommendation on that process. But my recommendation is that in one of our reports we did include in text some language saying a process much like the IOM recommended for development of measures might make sense. And IOM -- and Bob, correct me if I'm wrong -- IOM envisioned an entity would be created that would be responsible for a number of different activities, one of which would be measure development. And that process would be designed to bring in private payers as well as Medicare. So we're synchronizing the measures used for assessing providers. Is that right?

DR. REISCHAUER: It would go well beyond hospitals. It would be across all provider groups.

MR. HACKBARTH: And then Nick, when we talked last week I think you expressed interest in maybe going back and MedPAC's talking about that process and adopting a formal recommendation on it, in part because of the synchronization

issue, public/private, that Arnie has mentioned so often. But also one of your points has been that selection process really needs to be strategic. That's not just develop and use measures, whatever is available. We need to think carefully about choosing measures where there is important opportunity and then sending consistent signals for hospitals and physicians and other actors. These are our priorities for improvement.

So all of that is a long-winded way of saying that when we come back to this in March or April we may want to consider in some detail this process of measure development and maybe have a boldfaced recommendation on how we think it should work.

I will shut up and let other people talk. Any thoughts on this?

DR. WOLTER: Just a perspective on the 2 to 5 percent. Depending on the percentage of Medicare that a hospital sees, that could represent half or more of the total operating margin. It just think we need to keep that in perspective. It's a huge incentive, which is different than 2 percent, for example, in the physician world. And especially -- which we will probably talk about in the next

session -- when many hospitals, after all of the moving parts of the update are finished, don't really see much more than a 1 or 2 percent change. We really have some incentives here in play that we just need to keep our eye on.

I do think that if it was more explicit in this program that we're going to focus on high impact areas that would be good. In fact, I think a lot of the measures do, which I'm happy to see. But if you were to tackle post-op infections and line infections and ventilator associated pneumonia and a group of high impact problems, the odds of true improvement over a reasonably shorter period of time would be much higher.

I will mention again the utilization issue, if you want to look at the efficiency piece, because hospitals have their ways of looking at improving volume just as physicians do. The utilization rates and the geographic variability that you might see around certain services drive a lot of costs even though the unit price per se might not be the major issues.

We just have to get that on the list because it's a very difficult problem to try to address.

Could we connect this eventually, especially if we got some of those IOM ideas about how to create more organized design? Could we connect it to the physician resource utilization issue? I would think we would want to over time in terms of how this program unfolds.

Those would be the main things.

DR. MILLER: We were pressed for time in the previous discussion when you brought up the point about the physician resource use and the notion that it shouldn't just a focus on physicians. I think part of the frustration in all of these conversations is given the format that we work in and the reports and how we do things over time, we're always dealing with things in pieces. It's very hard, in each instance, to put the grand design together.

But Nick, you've made this point on hospitals and putting pressure there, as well. And today, after we get through the updates, we will have that discussion on bundling the physician and hospital payment, which Nick has urged us to do.

So I just want you to know we're not completely blind to the point that you're making. And we'll have a discussion tomorrow morning about the delivery system reform

issues that you've brought up which we haven't brought this to you yet, but start to get into the accountable care organizations and looking at larger groups.

One of the ways to think about the physician resource use recommendation -- and this isn't going to satisfy all of you -- is if each of the areas feels like their measurement is occurring there, some of that is to create pressure so they say actually I think it's better that we get looked at as a system instead of as individual silos. And I think some of the notion that Tom Dean was making, that everybody needs to feel that there's a certain accountability here. And then, for our other policies, to try and drive people into more systems and coordinated -- and measuring across that, which is I think is some of what you're getting at if I'm following you.

DR. WOLTER: I know we're beginning to work on it. I just think sometimes persistent reiteration has its value.

DR. MILLER: And I'm persistently saying I swear to god, it's coming.

DR. MILSTEIN: My sense of this is that it's quite good, it's directionally correct. For the reasons that Nick stated, I worry a little bit about a plan that would tax the

base 2 to 5 percent, more in terms of its political viability. Or if turned out to be politically viable, how the formula would be constructed so that everybody would do well.

I like the fact that it's a large amount but I worry that it will doom its political feasibility.

I guess I'd like to suggest a supplementary approach as I support this. But in addition, one of the things that we've talked about together before is the notion of some categories of providers having more potential leverage on how much is spent by Medicare on other providers, as well as in the case of hospitals a real opportunity to reduce the rate of future hospitalizations.

In view of those opportunities that are available to hospitals, it seems to me that it would not be unreasonable, separate and apart from this 2 to 5 percent recommendation, to really open up an opportunity for the hospital industry to gain share with Medicare with respect to its ability to reduce total spending, whether it be through reduced downstream admissions or reduced spending in other categories.

I think it's been signaled in the report by saying

at some point in the future, 2010, 2011, we'll work on measures for efficiency. I think there's a fair amount of evidence that with respect to sustainability the house is on fire now. And I don't think we need to wait that long. I think that thanks to Jack Wennberg and Elliott Fisher, we do have some quite well vetted in the peer reviewed scientific literature measures attributable now at the hospital specific level of total spending per Medicare beneficiary per year.

I would like to see an opportunity for hospitals to be able to gain share with Medicare to the degree they put in place changes that not only improve quality but also substantially improve how they stood on their -- I'll call it Fisher/Wennberg total Medicare fuel burn score which they have come up with.

I feel the same way about hospitals that would be able to -- separate and apart from that -- reduce admission rates. I think there is no reason to constrain how much hospitals might be able to earn through significant improvements in the amount of total Medicare spending or readmissions that occur for Medicare patients.

If we limit hospitals' opportunity to win on this,

sharing in a 2 to 5 percent tax on the base, I think we're missing a much larger incentive pool that might motivate much more substantial change.

DR. WOLTER: I totally agree with that, Arnie. In fact, that's really what the group practice demo does although not everybody in that has a hospital but 30 or 40 percent of the organizations do.

This is not reiteration, this is perseveration, but we also need to really stay very focused on delivery system reform for the idea you just advanced to work. I know you just said that, Mark, that that would be part of what we do. But we really do need to reform ourselves around are accountable care organizations to have the capability to tackle these problems. And so it's both how we look at the financial incentives but also how we look at how we can incent the delivery system.

MR. EBELER: Just a question about how this is linked with MA payments to hospitals. Given the MA overpayments, more and more folks are going there, the traditional leverage we've had, the Medicare fee-for-service payments to hospitals may slowly decline. I wonder if this project envisions any efforts to work with those plans,

particularly private fee-for-service plans, to get them to use the same incentives so that you really can't leverage the system.

MR. RICHARDSON: As far as I can recall from analyzing the report, it doesn't specifically contemplate that. I can certainly follow up with the CMS staff and get back to you on that specific issue. It is oriented around the fee-for-service DRG payments for the hospitals.

DR. CROSSON: I'll have a brief comment on that in the next topic discussion.

MR. HACKBARTH: Thank you, John. More on this in March or April.

Our last session this morning is on payment adequacy in update for hospitals.

DR. MILLER: Jack, just before we start, just two quick questions. Is it correct that this is your last presentation after 19 years of service for the various commissions?

[Laughter.]

DR. MILLER: Is that correct, Jack? I'm just trying to get an answer here.

MR. ASHBY: That is correct.

DR. MILLER: Is it also correct that you're going to Hawaii?

MR. ASHBY: That is correct, as well.

DR. MILLER: Okay. I just wanted to make sure that we had all of this straight.

[Laughter.]

MR. ASHBY: The Commission leadership is to be commended for this.

MR. HACKBARTH: In case you can't hear it, Jack, we have a little appropriate background music for your presentation, a little Hawaiian -- would you get on with it? We're behind schedule.

[Laughter.]

MS. DePARLE: Is he going to dance for us?

MR. HACKBARTH: We're on Hawaii time.

[Applause.]

MR. ASHBY: My thanks to the leadership and to the staff and to the commissioners here. We will still attempt to take a good hard look at hospital payments here.

MR. HACKBARTH: No offense, but this is cutting off the blood to my brain.

[Laughter.]

DR. REISCHAUER: Fortunately, I have no blood to be cut off.

[Laughter.]

MR. ASHBY: This session will address the adequacy of payments for hospital inpatient and outpatient services.

Before I start, I'd like to just remind you of a couple of facets of our hospital analysis here, and that is that we do assess the adequacy of current payments for the hospital as a whole. And that encompasses, along with acute inpatient and outpatient services, hospital-based home health and SNF, inpatient psych and rehab and graduate medical education.

And then I would also note that Medicare pays separately for capital in the acute inpatient PPS. And CMS, rather than Congress, sets the update for capital payments each year.

So our update on the inpatient side will apply only to operating payments and comprise about 92 percent of the total, while on the outpatient side it will apply to the single base rate encompassing both.

Just one last introductory comment, and that is that we are just going to review and basically summarize our

findings today. But you do have complete details on our various analyses in your briefing books.

We're going to begin by looking at payment adequacy leading up to our update recommendation and then we're going to move to IME payments.

We found that most of the Commission's indicators of payment adequacy are positive. We have seen a net increase in the number of hospitals, as well as an increase in hospital service capacity in recent years. The volume of services per fee-for-service beneficiary is increasing, including both inpatient admissions and outpatient visits. Our quality of care results are generally positive with mortality and process measures improving but with mixed results on rates of adverse events.

And finally, we found that access to capital is quite good as most directly evidenced by the substantial increases in hospital spending for new and expanded facilities. The hospital industry is indeed experiencing an almost unprecedented construction boom.

This next slide updates our overall Medicare margin estimates from the December meeting. The margin in 2006 was minus 4.8 percent, as we said in December. We

updated our projected margin from minus 4.5 to minus 4.4 percent. The extra one-tenth comes from the provision in the extenders bill last month to change payment policy for hospital-based rehab units.

The slight improvement going from 2006 to 2008 may seem counterintuitive given recent trends but you'll recall from the December meeting that the impact of several factors increasing payments like fewer hospitals affected by the transfer policy under MS-DRGs and our expectation that they payment increases from coding improvement will exceed the legislated payment offsets will more than cancel out the effects of factors that will decrease payments like the weight of cost growth continuing to exceed the market basket.

As Jeff reported at the last meeting, we found that hospitals' costs as well as their Medicare margins are related to the financial pressure that they are under from private payers. The key criterion we used in identifying hospitals as under high financial pressure was a non-Medicare margin of less than 1 percent while a margin of greater than 5 percent identified hospitals under low pressure.

The high pressure group's costs, that is their standardized Medicare costs per case, are more than 10 percent below those of the low pressure group. And for the industry as a whole we've seen that the rate of cost growth has been much higher during periods of low financial pressure from private payers and we've been in a period with low pressure/high cost growth since about 2000. When we isolate hospitals with consistently high costs, defined as those with standardized costs in the top third three years running, we find first that these hospitals not only have high costs relative to the national average but in almost every case they also have higher costs than their neighbors. So it's questionable whether these hospitals are competitive even in their own markets.

When we eliminate hospitals with consistently high cost from the margin calculation, we find that it raises the industry-wide overall Medicare margin by about 3 percentage points.

That brings us to our update recommendation. In considering the appropriate update, on the one hand our indicators of payment adequacy are almost uniformly positive as I mentioned a moment ago. But on the other hand, we

expect Medicare margins to remain low in 2007 and 2008. At the same time though, our analysis finds that hospitals with low non-Medicare profit margins have below average standardized costs and most of these facilities have positive overall Medicare margins. The Commission has generally felt that Medicare should put pressure on hospitals to control their costs rather than accommodate the current rate of cost growth which is, in part, caused by this lack of pressure from private payers.

So in balancing these considerations, our draft recommendation is that the Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2009 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentives program.

The existing law is a market basket increase so this update would have no implication for spending and we expect no major implications for providers, but there is potential for improved quality of care for beneficiaries through the implementation of P4P.

The tie-in to P4P implies that poor quality performers would have a net increase in payments of less

than market basket while good performance would likely have a net increase of more than market basket. The P4P program would operate separately from the update. We have to be sure that qualification is understood. But it would be the update and the hospital's quality performance that determine its net change in payments for the coming year.

Then just to review here, we make note of the fact that the Commission recommended a quality incentive policy for hospitals in 2005 and, as you heard in the previous session, CMS's recent report outlines the value-based purchasing program it plans for 2009.

So at this point, we would turn our attention to the potential recommendation on IME payments.

MR. LISK: Aloha.

I'm now going to briefly discuss the indirect medical education adjustment. The IME adjustment is a percentage add-on to the PPS rates that varies with the number of residents a hospital trains. In 2006, IME payments to hospitals totaled more than $5.8 billion and went to 30 percent of hospitals. The current IME adjustment, however, is set at more than twice the documented impact of teaching costs on hospital costs.

Analysis we conducted last year showed that the inpatient costs in teaching hospitals increased about 2.2 percent for each 10 percent increment in teaching intensity as measured by the resident-to-bed ratio. But the adjustment is set so that payments increase 5.5 percent for each 10 percent increase in this ratio, resulting in a $3 billion subsidy to teaching hospitals with no direction or accountability for how these funds are used.

Having the adjustment set considerably above the true cost relationship contributes substantially to the large disparities in financial performance under Medicare. In 2006, the overall Medicare margin for major teaching hospitals was 11 percentage points higher than that for non-teaching hospitals. The difference was even bigger if we focused on the inpatient margin, which is where the adjustment is made. It's 17 percentage points.

In 2008, we have the introduction of severity adjustment with MS-DRGs being implemented. This difference, we expect teaching hospitals will benefit more than other hospitals from the introduction of severity adjustment. So these differences also likely will grow with this introduction of the MS-DRGs.

Reducing the IME adjustment closer to the empirical relationship would help to reduce disparities in financial performance. A one point reduction in the IME adjustment to 4.5 percent per 10 percent increment in resident intensity would reduce the gap in overall margins between major teaching and non-teaching hospitals by 2 percentage points. It would also make available nearly $1 billion in Medicare payments that could be redistributed to hospitals for a quality incentives program, which Jack just discussed. Using the savings from reducing the IME to help support a pay-for-performance program provides a more focused use of these funds that will benefit both teaching and non-teaching hospitals.

Last year, the Commission recommended that the IME adjustment be reduced by one percentage point to 4.5 percent with the introduction of severity adjustment to the inpatient PPS and that the savings be used to support a P4P program. Now that a credible severity adjustment has been implemented for the introduction of MS-DRGs starting in 2008, we have the following draft recommendation for your approval. It reads the Congress should reduce the indirect medical education adjustment in 2009 by one percentage point

to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained by reducing the IME adjustment should be used to fund a quality incentive program.

Moving on to the spending implications, there would be none as the recommendation is intended to be budget neutral.

For providers, we would see a narrowing in the disparity of Medicare margins while at the same time making funds available to reward high-performing hospitals, both teaching and non-teaching hospitals.

With a P4P program, there is potential for improved quality of care for beneficiaries.

And with that, we would be happy to answer any questions you may have.

DR. BORMAN: I wonder if I could ask a couple of questions that would help me to think about this a little bit. I do believe that there are some differences in the nature and amount of costs that go into graduate medical education than existed when the formula was created. Just so, for an example, can you help me to understand where if a teaching hospital invests say $1 million in simulation

technology equipment, where that's going to reflect in how that's captured in this analysis?

MR. LISK: We are looking at their overall average cost. So those costs would be part of the costs of the hospital cost. So those higher costs would be reflected in that 2.2 percent increment that we see on average that teaching hospitals have.

DR. BORMAN: So that you believe that in this calculation that new educational, program, structural, equipment costs are captured in the way we get the data now?

MR. LISK: Yes, if they're part of the hospital's costs. There are issues about whether those costs come from a medical school and then that would be a different story about what transactions take place between the hospital and the medical school, for instance. But yes, they're part of the hospital costs.

And to the extent that they are considered in the direct GME portion of the costs, in terms of the structure of the medical education program, they would be captured in that part. But that is a separate piece than what we're talking about with the indirect medical education adjustment, which is for adjusting for the differences in

the operating costs of the patient care costs rather than the training costs which is part of the direct GME payment which is separate.

DR. BORMAN: I was with you until that last part.

MR. LISK: We have two payments. So there's the hospital payment, which includes an adjustment for differences in patient care costs --

DR. BORMAN: So you're suggesting it's in DME and not IME?

MR. LISK: No, I would say something like that would probably be something that's part of the hospital structure.

DR. BORMAN: The hospital cost report.

MR. LISK: Part of the hospital cost structure, it would be part of that.

DR. BORMAN: I would still have just a little bit of concern that there may be some things that we're not appreciating here, but I also absolutely acknowledge that the academic community probably has not brought that forward in a clean and crisp way and quantitate it.

My next question would be I believe that a couple of years ago, if I recall right, it's the S-10. There was

supposed to be some additional reporting from teaching hospitals to try and get a better handle on what is being tracked here, what is being bought here by these monies. There were some issues with the nature of the form and whether it collected the right stuff, whether it was possible. Do we have any update on where that data collection process is? Are we going to ever have some data from that source?

MR. ASHBY: I'm not sure that I can really give you an up-to-date indication on that but it is in process.

DR. MILLER: Wait a second, Jack. You've worked through with CMS -- we're talking about the uninsured data collection here; right?

MR. ASHBY: Right. It is in process and CMS does indeed promise to implement a page to collect that information. They haven't given us a date yet but they have indicated that it is forthcoming.

DR. MILLER: And Karen, the point I just wanted to get across is Jack has spent a lot of time working through the form and revising the instructions so that it collects what we think would help. So we've been pushing on this. But what he's I think saying is I can't tell you what CMS --

DR. BORMAN: We're still nowhere close to having information from that.

MR. ASHBY: Let me just refine that to say we may be fairly close to their making the formal publication of their intentions. But then there will be an approximately two-year gap before we actually have usable data.

DR. BORMAN: And then the other thing was, as I recall when we previously looked at the mostly bell-shaped distributions of the payments, both just the IME payments and the IME plus DSH payments, that there is certainly a pretty significant tail to the right at the high end folks. I certainly think we certainly can look at the margin material that you presented to us.

I remain a bit concerned about the folks at the other end of the tail and I worry a bit about whether part of what we're picking up here represents in part a geographic distributional issue as much as it represents a teaching versus non-teaching fairness issue. I certainly respect the comments that Nancy has made in the past about that. But just for an example, I would hazard -- and I can't say that I have data to support this -- that, for example, sole state academic medical centers, particularly

in the Southeast and Southwest and perhaps parts of the Midwest, may in fact be more clustered to the leftward tail of that curve and perhaps are not experiencing quite the bonus use of these monies as might be anticipated at the other end of the curve.

So I remain a bit concerned that this is a relative broad brush to address what may, in fact, be a somewhat more discreetly dotted problem. But I absolutely respect the analysis that's been done and I have no data to say that you're incorrect.

MR. HACKBARTH: Karen, I want to just go back for one second. There are two distinct issues here. One is how much do teaching hospitals and other hospitals spend on uncompensated care? That's a difficult question to answer but I think it is answerable with some real effort.

Another question is where do the indirect teaching dollars go? How are they used? I would argue that that's inherently unknowable. Money is fungible. Once it goes into a hospital's general fund, the dollars that came from IME don't continue to have IME marked on them. Once it's in the general fund, everything can be used for any purpose.

So having teaching hospitals report this is how we

use the IME dollars I think is an abstract, irrelevant exercise. You couldn't take the data seriously.

In Washington, when I was involved in government, there used to be the notion of shutting down the Washington Monument. So you'd say we're going to cut the Interior Department's budget. What they would say is if you cut that money what we're going to do is shut the Washington Monument and try to say oh, that's impossible. If you cut the Interior Department's funding there are a million places that could be cut. But the nature of these exercises is oh, it's the most vital thing that's going to be cut. That's not a serious exercise.

So let's not go down the track of saying let's have teaching hospitals report what this money is used for. That's not productive. Let's go down the track of do teaching hospitals in fact do something meaningfully different on uncompensated care or other activities that we think are important?

DR. BORMAN: If I could just respond briefly to that, I do think that knowing or having some sense of where the money goes perhaps helps us move toward how we would incent better behaviors of those institutions. I share your

point. When I write my check to Georgia Tech Foundation, I am under no illusion that it doesn't enable dollars for the athletic program. So I certainly understand that concept, Glenn. And I guess I would just comment at this point, as you and I have discussed, that there certainly are issues with is the money being delivered to the right entity to achieve the values that we want from it? And that's a whole other discussion.

DR. KANE: So I am going to try one more shot at why I would like to see the payment from IME redistributed to the base, although it's not a do-or-die for me. I do think there's some issues that we haven't really had a chance to talk about.

And one of them is if you look at the bottom third, the lowest cost hospitals, not all of them are profitable. And I suspect -- and I think I asked you about this before -- if you take out IME and DSH -- I'm trying to remember and maybe you can help me, Jeff -- what percentage of them remain profitable. But I think it's 50 or 52 percent or something like that?

DR. STENSLAND: [Off microphone] If you take out IME additions, it's going to be a little over 50 percent

that have a comparable overlay Medicare margins, higher than that they have a profitable inpatient work but still not all of them will have a profitable inpatient margin.

DR. KANE: Where I'm coming from and why I'm concerned about that the lowest cost hospitals are still not necessarily profitable is that a lot of hospitals are saying -- it's a completely different area but it's the impression. A lot of hospitals are saying they want to have Medicare shortfalls count towards community benefit because they really feel it's a charitable act.

I feel -- we keep saying no, the hospitals that are efficient are adequately compensated. And yet, if you're in the lowest third cost, you're still losing money even though it might be from another part of the business, the outpatient or the rehab or whatever. I feel it's really hard for us to continue to stand here and say that the most efficient hospitals are adequately compensated.

So it's really more philosophical but I feel if the bottom third in cost are still not -- only 52 percent of them are profitable if you take out IME and DSH -- that we aren't fully compensating the most efficient hospital.

So I'm really saying we need to address that.

I'm a little concerned, too, that it takes a little profit to be able to afford to improve your quality. Hospitals have to invest in operational analysis. They have to often hire consultants. They have to buy information support systems. They have to hire a higher skill mix. It costs money actually to get these higher improvements that come out later. If you're always on the edge, it will be much harder to look good on our quality improvement measure.

So I'm just trying to get a more level playing field for those who haven't been able to make money on the Medicare payment system, especially those who are already efficient. Unfortunately, we can't necessarily detect those and redistribute the money that way until eventually they get efficiency built into the pay for performance.

So I'm not talking permanently taking the 1 percent IME out and distributing it to the base, but I think there is a real issue about equity here and ability to afford improvements to make the quality measures look good.

The only other thing I wanted to talk about is that in looking at the pressures that we talk about, the high payment pressure versus the low payment pressure markets, we've consistently never -- as far as I can tell in

the time I've been here -- we haven't said much about market concentration or made any kind of comment about antitrust or merger issues.

But yet I just read a great study that I think RWJ put together saying that markets have been coming increasingly concentrated over the last 10 years. The impact of that is that the private sector has less market power to produce lower payment rates. If we then say well then that's causing the pressure to have Medicare pay more because the costs are going up, should we be starting to talk about market concentration and where we think the Feds should be going or the Federal policy should be going around antitrust policy? Because we've seen in the last 10 years a definite increase in market concentration in major markets. And that's been documented elsewhere and I'm happy to share what I know about that.

MR. HACKBARTH: Nancy, I'd like to just go back to your previous point. In this payment system, as in every other Medicare payment system, there are important issues of equity and whether we're paying fairly for different types of providers.

In the case of the hospital payment system over

the years, we've made many, many recommendations aimed at increasing the fairness of the payment system and making the payments more accurate, a recent example being severity adjustment. But we've made recommendations on the base rates, urban versus rural, on wage index, a host of issues, each designed to improve payment accuracy and fairness.

Are there more out there? To be sure. But I think we've done a lot on that front.

Having said that, I wanted to react to the notion that well, hospitals need money to invest in improvement. The information that we have is that hospitals are making large scale investments, unprecedented investments, of various types, in new facilities and updating of facilities and new pieces of equipment and the like.

So I think it would be difficult to argue that the dollars aren't available for investment. The question is what is it being invested in? And there I think we do have an important payment issue that, for example, if you're a hospital administrator looking at the alternatives of investing in a new scanner or in clinical information systems, the system says oh, do the scanner. It brings revenue. It has a revenue stream. There is a return on

your investment. Whereas you improve the quality and there's no payback.

That's why I think pay for performance is important, in general. I think we're ready to go with hospitals. CMS has produced a report that addresses many of the issues that need to be addressed. It's time to get on with pay for performance to start rewarding the right investment.

DR. KANE: Just to respond to the rise in capital spending, I agree that it's a big opportunity to look at where the money is going. But there is a distributional aspect to that, too. The hospitals that are under a lot of financial pressure and aren't making money on Medicare are going to be disadvantaged.

I guess I'm just going back, I agree, we do need to address the capital spending. But the distribution of the capital spending is just as big a problem as it was, as the distribution of the payments.

DR. REISCHAUER: But you aren't suggesting that the money go to the "needy." You're suggesting that it go into the base, which means everybody gets it.

DR. KANE: If I could direct it to the lowest-cost

third, I would. But right now I can't. That hasn't been on the table. But that would be the ideal. I mentioned that. So the next best might be to put it in the base and then use quality, and then do the quality.

And I'm not against the quality adjustment after that. But I'm just saying for the IME, I'd like to see it go in the base because I think there's been historic competitive advantage distributed through the IME to the hospitals that have major teaching programs.

DR. CROSSON: I support both the recommendations but I'd like to make a couple of comments. The first one has to do with a point that came up earlier, and that is that in the case of Kaiser Permanente and our 31 hospitals and potentially other organizations who are paid through the Medicare Advantage program, the particular recommendation will take the IME payment away but there will be no opportunity to participate in receiving it back since the payment is through the Medicare Advantage plan and the pay for performance program that is in the recommendation is through fee-for-service payment to hospitals in traditional Medicare.

I would like to request that that at least be

noted in the text, and perhaps there might be an opportunity for later discussion about moving ahead with some process to fix that.

Nevertheless, I support it. The reason I support it is I think, as the staff has brought forward earlier in discussions, this particular area of IME payment is an area of pretty obvious overpayment since the formula is about twice what the analysts understand is the underlying cost. So in our fiduciary responsibility as a Commission, those are exactly the areas that we're supposed to be looking for and taking action on.

I do have one other concern and I think it's quite similar to Karen's, and that has to do with the fact that -- as you might expect -- all teaching hospitals are not the same and not in the same situation financially. I would point out -- I think it was in the New York Times in the last week -- where they had a long page discussion about the plight of Grady Memorial Hospital in Atlanta, which has been a fixture of that community for a long time. I don't know what their operational issues are or where they are in their costs or anything like that.

But I do think that it might be worthwhile for the

Commission to spend some time in the next year or so picking apart with the data this issue that Karen brought up about the interrelationship between DSH payments and IME payments and what exactly is going on in the teaching hospitals. And do we, in fact, have -- we clearly don't have a homogeneous population. But do we have sort of discrete categories of teaching hospitals? And if we are going to continue or consider continuing this approach to reducing IME payments, would we want in the future to make some kind of more targeted approach?

DR. CASTELLANOS: I support both of these motions, too. I just have two points.

One is Jeff last time mentioned -- he talked about high quality/high cost. He talked about high quality and low cost hospitals. He kind of mentioned that the relationship there was that there was a strong physician/administration relationship. Since we're going into bundling, I would like to try to drill down a little bit on that.

I don't think we need to bring it to the Commission's level unless it's really pertinent, but I'd like to get some drilling down on that to see what are these

relationships? What are they doing? Is there any common thread?

I think the Hospital Association, and I think the medical associations, would like to look at that. So I just ask that if we could drill down on that and get some additional information, I think it may be very productive.

MR. ASHBY: Let me just add that those findings were from specific hospitals that we visited that exhibited those strong physician/hospital relationships and we could extend that.

DR. CASTELLANOS: I would appreciate if you could. That was, I think a point that I would enjoy looking at.

The IME issue has been discussed. There's no question there's an overpayment. I don't question that at all. Again, I question the message that's going out to the teaching hospitals. I think there's two good messages. One, you need to be more active in what you do. And you have to be more accountable in what you do. But again, the medical schools have been increased in numbers. We've had nine new medical schools this past year. We have not increased the specialist.

Again, there was an article I brought up earlier

in Maryland showing that there is a shortage of specialists today.

I agree it's going to be hard to find accountability of this but it doesn't hurt to look. And Karen's point and Jay's points are very well taken.

I would wonder if we could put in the text, somewhere in the text, that perhaps Congress could consider not this money but directing some monies or funds to the medical school to establish a department of health policy -- for a better word -- which would include some of the core values that we discussed: the evidence-based medicine and comparative effectiveness. This needs to be started right in the medical school, not in the residency program. It's too late by then. We need to get the core values right from the get go.

Thank you.

MR. EBELER: Thank you, just a couple of quick things.

As I understand it, the implications of the recommendations are everybody gets market basket minus one or two. That one or two plus the IME money is in a quality performance pool of some sort that gets distributed

depending on how you do. That's where we're headed. I think the issue about whether or not one needs to allocate more across the board depends on how you read the public and private data. By one look, you say gee, Medicare has negative margins, private sector has positive, therefore Medicare is under paying.

I think the other way to read that data in a dynamic hospital market is that they manage the total margins. Given the generous payments on the private side, costs float up, and therefore Medicaid is paying less.

I'm inclined to read it the latter way, just given what I've seen out there. But it seems to me that's the way the analytics turn.

Where that takes you, I think, from my personal view as I indicated at the last meeting, I would be more than happy to try to achieve some net savings here through a productivity offset of some sort. But As I hear the discussion, and I think what we're talking about, the better part of valor is with these recommendations, to take the money from the IME savings and from the market basket update and reallocate it within the system based on performance which is really what we're talking about here.

DR. REISCHAUER: I think, if my arithmetic is correct, we're having a debate about nothing.

MR. HACKBARTH: It's a Seinfeld moment.

DR. REISCHAUER: It was because I had this on, I suddenly began thinking clearly.

If you think that the decision rule is we're going to spend X billion dollars, a fixed amount of dollars, on pay for performance in the next year, it doesn't matter whether we take the one percentage point and put it into that pay for performance pool and then reduce the DRGs by a certain percent to make up the X billion dollars or we take the money and we add it to the base and then take all of it out of the base. It's the same amount.

The only way it's different is if you say pay for performance should be X percent of the base, in which case it's a bigger pay for performance program under one thing than it is under the other. But that would be a stupid way to go about deciding how much to spend on pay for performance in the initial year.

So I don't think we have an argument here. Your hospitals will get the exact same amount down at the bottom in their standard DRG payments under either of those --

DR. KANE: Only if they get the quality.

DR. REISCHAUER: I'm saying X the quality issue.

DR. KANE: To go back to Dave's comment a while back about the message, I actually think the money isn't the issue. It's a message.

But no, I don't agree. If you're in the low-cost third and you don't get your money back because you're not able to do well on the pay for performance variables, then you would actually be paid less than you would if 1 percent of that was distributed to your base rate, I think. It depends on when you start with the base.

DR. REISCHAUER: You're taking the same amount out of the base to set up a pool. The pool consists of a certain amount from the IME and a certain amount from the base. But they sum together to the same amount of money.

DR. WOLTER: This is a striking moment in my MedPAC tenure because I was having the same thoughts as an economist.

DR. REISCHAUER: It's time to quit.

MR. HACKBARTH: It's time for you to get off, Nick. Your bell has rung.

[Laughter.]

DR. WOLTER: I guess the question is if we decided on a 2 percent pool for pay for performance and 2 percent of it came out of the base and the 1 percent IME went back into the base, it's kind of the same result as if we did 1 percent out of the IME and 1 percent out of the base to most institutions. I think that's what you're saying.

DR. REISCHAUER: But the one percentage point from IME doesn't amount to the same percent of the base. You have to translate.

DR. WOLTER: Oh, good, I didn't have exactly the same thought as an economist.

Just a couple of things from my perspective on this. They're a little bit linked to some of what Nancy was asking about. I'm a little bit worried about the balance in the story we're telling here, that somehow the Medicare margin is totally related to the discipline of the management in 20 percent of the hospitals, which I'm sure has a role. There's no question.

The thing I'm interested in is can we connect some of these dots also to the other very complex moving parts on the reimbursement system? Which hospitals are reclassified? Which do get large amounts of IME and DSH? Which do have

large wage indexes? Have people make changes in their service mix, which might be good or not so good for their community to help drive these things?

And then I think it should be quite obvious the markets are not the same across the country. And so how do we take that into account? The story we're telling here has got a very sharp point but there may be nuances that we'd like to flesh out over time so that we understand what might be the next step, which I am glad to hear we're going to look at the framework for an update because I don't know what the implication of this is. Would we only give an update to that 20 percent of hospitals of one size versus a lower to the other? Even those getting a 3 percent margin, as Nancy pointed out, might need some kind of an update to continue into the future.

So how do we take this information and use it in the framework we want to put together for future updates? I hope we can connect some dots as we move ahead.

MR. HACKBARTH: Before we turn to the vote, let me just share Tom Dean's comment here, and I'll quote a few lines from it. He said I support the hospital recommendations, though again I have some reservations about

the fairness of the distribution. I'm bothered by the fact that so much of our -- and these aren't consecutive sentences, I'm collapsing here.

I'm bothered by the fact that so much of our judgment is based on average margins. I do not believe that Medicare is obligated to deliver any provider a predetermined margin. I do believe Medicare is obligated to pay a fair price for services delivered and it's up to providers to figure out how to deliver services in an efficient way. At the same time, I understand how difficult it is to determine what fair means.

The bottom line is he said he would vote for the recommendations.

It's time for everybody else to vote, so on recommendation one, all opposed to recommendation one? All in favor? Abstentions?

And on recommendation two, all opposed? In favor? Abstentions?

Thank you. Good job.

MR. ASHBY: If I could just say one last thing. I want to thank you all for the aloha reception you've given me today. But more importantly, I'd like to thank Bob and

Glenn, and particularly my boss, Mark Miller, for giving me a tremendous opportunity to grow professionally and hopefully to contribute over the 19 years that I've been here.

Aloha to everyone.

[Applause.]

MR. HACKBARTH: Thank you, Jack, for your service.

Yes, site visits, the sign-up list is...

Okay, before lunch we now have a brief public comment period with our usual ground rules which are number one, please identify yourself and your organization. Number two, please keep your comments to no more than a couple of minutes. I'm going to turn off my microphone but when you see me turn it back on and the red light goes on, that's the sign that the hook is coming out.

MS. RICHNER: I'm Randel Richner and I'm representing a home hemodialysis company called Next Stage in Massachusetts. I was formerly a home dialysis nurse for 12 or 13 years and have been part of the medical technology policy world for quite some time. I have served on MCAC, the original MCAC, and they asked me back for a couple of years, I think for entertainment services.

Given that ESRD is 7 percent of the overall costs of Medicare and dialysis, and it's been brought up at every MedPAC meeting, I wanted to note for the public record that a small part of the ESRD program, home hemodialysis, could yield significant savings to CMS if the payment system was modified to encourage this choice.

Currently, home hemodialysis is a treatment choice for patients that will completely fail due to the misaligned payment systems if Congress or Medicare does not initiate some reforms. There is no payment accommodation to encourage home hemodialysis and, in fact, providers have payment disincentives to encourage it.

In recently published articles from Canada, from foreign countries including California -- which some consider a foreign country -- there was a robust study done at Kaiser showing the significant savings associated with home hemodialysis related to the improved patient outcomes with LVH and anemia status, nutritional status, and all the other important markers in quality of care.

The problem is that once again the savings straddle Part A and D. As many of the commissioners noted this morning, the issue is primarily again the problem of

one system realizing the benefits and the others not. So therefore, providers will continue on the status quo, encouraging institutional care with these misaligned incentives.

I urge the commissioners to continue to encourage Congress and Medicare to creatively examine and reform some basic payment mechanisms to support home hemodialysis. The proposed bundle change may or may not do this to ensure that providers will choose developing home hemodialysis programs without careful examination of the link to provider payment, frequency, drug payments, and utilization.

I applaud all the efforts of MedPAC, from the reports that have been published over the last several years, that recognize this. But we still have a long way to go and I hope that will be brought up in the March payment report.

Thank you.

MR. DICKLER: Mr. Chairman and members of the Commission, I'm Robert Dickler, Senior Vice President of the Association of American Medical Colleges. Let me make three brief comments.

The first is while we appreciate your continuing

attention to IME, we'd like to suggest that the discussion be somewhat expanded.

First, as was noted earlier, there are a lot of moving parts currently in Medicare and other Federal programs, including Medicaid. Many of those are targeted to teaching hospitals or have a differential impact. We would urge the Commission to take a look at those factors in aggregate in terms of the impact on the teaching hospital community and their ability to fulfill their missions.

Second, historically IME has been an overpayment. It's been recognized since the inception of Medicare. And it has been recognized in the context of mission and total financial viability. We would urge the Commission to reconsider looking at total margins, not simply Medicare margins, as they deliberate the IME in terms of the financial health of that community.

And third, a number of very interesting points were raised. We would be delighted to work with the Commission on pursuing any or all of those as you determine appropriate.

Thank you.

MR. SHAW: Hello, I'm John Shaw and I'm the

President of Next Wave. That's a health systems research and policy organization in Albany, New York. I'm here primarily to talk about value-based purchasing, although listening to the recent discussions, I think it has an impact on that as well.

In point of context, I sat with Tom Dean during both of the CMS listening sessions for value-based purchasing. And I'm sure if he was here, he would add an additional area to the areas to look at for value-based purchasing, and that is the plight of the small and rural hospitals relative to the fixed cost of collecting and reporting the data to support the system.

We did some analysis and made some recommendations that didn't find their way into the final paper to Congress, but essentially what we suggested is you may want to set aside a portion of whatever funds are in the pool to pay for the cost of just collecting the data. For a small facility, that could very well be 2 percent of their Medicare volume just to report the data. Under the performance scenarios in year two and three, they would very likely not get that back, in which case why would a small facility on purely financial record go forward and do it?

So we looked at probably the cost of reporting. The numbers we used are about $50,000 for under 100 beds, $100,000 from 100 to 200, and $200,000 over that.

Pull that out as a separate pay to report piece and apply that before any distribution on performance.

The second area of refinement is to look at the other end. What to do with the funds that would be available but not distributed potentially or redistributed? We agree completely that any of the funds should be redistributed but suggest considering how to do so. There's a lot of discussion about the distributional aspects and some of the facilities that don't have the resources to necessarily implement some of the performance improvement.

The concept that we floated at the April listening session was to take the unallocated funds and use it to fund pay to share. In other words, looking at performance you have achievement and improvement, both of which are recognized, both of which were specific elements that MedPAC had in their papers from several years ago. Those are being implemented, measured, and defined. But there's money left for 95 percent of the hospitals. Eventually, when it gets into years two and three, that would not be distributed

according to those formulas.

Take that money, set it aside, and specifically target it to fund the top performers to share their best practices with the ones who need improvement. And that accomplishes many things. It takes the expertise and makes sure it gets in there so that it helps raise all boats because here is something more that the top performers can do. It gives the --

MR. HACKBARTH: I'm going to have to cut you off here. I would encourage you to share your ideas directly with the staff via letter, phone call, meeting, whatever you think is best. But we need to move on right now.

MR. CONLEY: Thank you, commissioners. Jerry Conley on behalf of the American Academy of Family Physicians.

We would just like to share with you a perspective based on an observation of this morning's discussions around certain recommendations, around the action that you take with regard to the specific recommendations, particularly with regard to hospitals and physicians.

If you look at the physician environment -- and this is coming from your discussion this morning -- warning

signals abound. You've got a history of at least six years now, almost seven, where payment updates have been insufficient and inadequate and less than the increase in the cost of managing and operating a practice.

You also have the adverse effects of reimbursement that are showing up in some other issues such as access and in other issues such as selection of medical specialty. I'm speaking specifically, of course, of primary care.

We get to the discussion of the hospital environment. And for the most part all of the indicators are positive. You have one indicator, that is the Medicare margin, which is negative but actually improving somewhat. And by the way, Medicare margins are not available for physician practices, as you know. Particularly wouldn't it be interesting to know what a primary care physicians' practice entails in terms of cost and managing for a Medicare beneficiary who has three or four or five chronic conditions?

So when you have a negative Medicare margin in the hospitals, obviously you're assuming in this system cost shifting. Cost shifting is increasingly something that physician practices are unable to do.

So at the end of the day we have a hospital update recommendation for the full market basket and you have the physician update recommendation was for MEI minus the productivity adjustment which is going to come to around 1 percent. So you still another year of an update that would be less than the increase in the cost of operating a practice.

This is just information and perspective that we would like you to seriously consider this afternoon as you talk about distribution of payments.

Thank you.

MS. COYLE: Carmela Coyle with the American Hospital Association. Thank you for your consideration and recommendations on the inpatient and outpatient update.

In the year area of IME cuts, we continue to be concerned about any cuts in Medicare payments to teaching hospitals at a time when these hospitals have among the lowest financial performance of all hospitals in the United States and at a time when people continue to be concerned about the future supply of physicians in this country.

Two brief comments. In the area of value-based purchasing, would like to suggest that the Commission might

want to consider bringing in and hearing from some of the folks who are involved in that process today. As you know, there exists a hospital quality alliances that has been up and running for several years. The National Quality Forum is obviously a very important player.

You talked a lot about measure development. Janet Corrigan is an example at the National Quality Forum, really leading in that effort around measure development and specifically measure endorsement. But an opportunity perhaps for the Commission to follow through the entire process from measure development to endorsement to selection to implementation on to data collection reporting and then actually sharing the information publicly and evaluating that. It just may be helpful to the Commission as you consider this. I think one of the concerns is how do we not reinvent the wheel in terms of some of the activity already out there?

My second comment is to Jack Ashby, to say thank you on behalf of the American Hospital Association, and I'd venture to guess on many of us in the policy community. Jack, we thank you for your dedication, for your years of service, you professionalism, your thought leadership, and

we appreciate everything you've done on behalf of health and health care in America.

Thank you.

[Applause.]

MS. McILRATH: I'm Sharon McIlrath with the AMA.

I won't dwell a lot on what the current financial situation is for physicians other than to say that there are a number of other things that are happening simultaneously with budget neutrality that mean that even the 0.5 percent increase for only six months this year, most physicians are still going to be looking at a pay decrease this year as opposed to even that slight bump up.

The other thing though that I wanted to follow up on was the productivity issue and to encourage you to perhaps include something on that in the report language. I think if you go back and look at what's been happening to the MEI, which is not exactly the same as your recommendation but similar, it's gone from 2.8 to 1.8 now down to it looks like 1.1 as you are doing it now.

One of the key reasons for that is because the productivity factor jumped. In 2006, BLS redid the way that they make that estimate. And so that had the impact of

bringing down all of the updates.

The other impact is that next year, forget about the 10 percent that you're going to be going down because we've only built this in as a bonus. There will be, on top of that, a 6 percent -- not a 5 percent, it's been being 5 percent. But it will be 6 percent because the formula calls for MEI minus seven. So you'll be looking every year, we've been looking at reductions of 5 percent a year. We'll now be looking at reductions of 6 percent a year. That obviously has scoring implications for either a long-term or the year-by-year fixes that we do.

Honestly, the best way to have it be fixed would be if CMS were to do it because of the scoring implications. They have actually looked at it. They did have a conference in fall of 2006 and I believe they're going to be publishing a paper soon. But the takeaway from the meeting that they had, I believe, was that the particular new adjustment that they looked at, the formula, had a lot of proxies in it and other economists were not comfortable with those. But there was some general agreement that the current one is too high.

So if some of the comments and the concerns that people here had expressed about that productivity adjustment

were in the paper, I think it would be useful.

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

[Whereupon, at 12:35 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION [1:36 p.m.]

MR. HACKBARTH: Our next session is on payment adequacy and update for skilled nursing facilities.

But before we do that, Carol, I just wanted to acknowledge another staff departure. Earlier we acknowledged Jack Ashby's service to MedPAC and its predecessor commissions.

Unfortunately, we're also going to soon be losing Sarah Thomas as the Deputy Director of MedPAC. Sarah is leaving at the end of the month to take a position with the AARP -- our loss is Jenny's gain -- as a Director within the Public Policy Institute at AARP.

It's a huge loss for all of us, both as a Commission and individually. Sarah is a really unique combination of intelligence and experience and wonderful personal qualities, and a dear friend to all of us.

Thank you, Sarah, and we'll miss you.

[Applause.]

MR. HACKBARTH: Carol.

DR. CARTER: Last month we considered the adequacy of Medicare payments, a pay for performance program for SNFs, and the publicly reported SNF quality measures. I'll

briefly review that information and the draft recommendation.

The indicators we examined suggest that payments are more than adequate. Most beneficiaries appear to have little or no delay in accessing SNF services, especially if they need rehabilitation services. Medicare continues to be considered a good payer. The supply of SNFs was almost identical in 2007 although the share of hospital-based units continues to decline.

When adjusted for the number of fee-for-service enrollees, days and admissions increased. The quality indicators showed mixed performance: risk-adjusted rates of community discharge within 100 days are almost the same level they were five years ago, having declined -- that is, they got worse -- and then improved during the last two years. The risk-adjusted rates of rehospitalization has steadily increased throughout the period, indicating poorer quality.

Access to capital is expected to be tighter over the coming year but this is related to broad lending trends, not the adequacy of Medicare payments. Medicare continues to be a preferred payer.

Aggregate Medicare margins for freestanding SNFs were 13.1 percent in 2006. This was the sixth year in a row that freestanding facilities had aggregate margins exceeding 10 percent. There continues to be wide variation in the financial performance across the facility groups as you can see from the margins in the top and bottom quartiles. For-profit SNF margins averaged 16 percent. The considerably lower margins of the not-for-profit SNFs are partly explained by their higher daily costs. They are about 10 percent higher. And between 2005 and 2006 they had higher cost growth compared to for-profit SNFs.

Hospital-based facilities continue to have large negative margins, negative 84 percent. We have often discussed the reasons for the large differences in per day costs between hospital-based and freestanding facilities, and these include their higher staffing levels, unmeasured case-mix differences, the allocation of overhead from the hospital, and different practice patterns of their physicians.

This past spring we reported on work that examined hospital-based SNFs. We found that some hospitals elect to keep their SNFs open, even with their negative margins, in

part because the units allow the hospital to discharge their patients sooner than they would otherwise be able to. We found that when the hospital and SNF stays were considered together, the combined hospital and SNF payment covered their direct costs.

The Commission continues to be concerned about the differences in financial performance between hospital-based and freestanding facilities and between for-profit and not-for-profit facilities. In the fall, I presented research exploring alternative designs for the PPS that better target payments to non-therapy ancillary services and that base therapy payments on care needs and not service provision. We plan to present more results in March and anticipate that the alternative designs will redistribute payments to hospital-based and non-profit facilities. Redistributing payments would narrow the differences in financial performance.

In modeling 2008 payments and costs, we consider policy changes that went into effect between the year of our most current data, which was 2006, and the year of the margin projections, 2007 and 2008. We also take into account policies scheduled to be in effect in 2009. Except

for accounting for the full market basket updates for each year, there were no other policy changes to consider.

We estimate that the Medicare margin for freestanding SNFs in 2008 will be 11.4 percent. This continued high margin is partly the product of having received full updates for the past five years. Our projected margin is a conservative one because we use actual average annual cost increases since 2001 and not their market basket which is lower and we did not factor in any behavioral offset that may increase payments.

This leads us to our draft recommendation, the Congress should eliminate the update to payment rates for SNF services for 2009.

This recommendation would lower program spending relative to current law by $250 million to $750 million for 2009 and by $1 billion to $5 billion over five years. It is not expected to impact beneficiaries or providers' willingness or ability to care for Medicare beneficiaries.

Now I'm going to switch gears and discuss the two quality related topics: pay for performance and measures of SNF quality.

When the Commission first considered the settings

that were ready for linking payments to quality, SNFs were not among them mainly because the widely acknowledged problems with the publicly reported quality measures. Since then we have carefully examined two measures -- rates of community discharge and potentially avoidable rehospitalizations -- and found that they meet MedPAC's criteria established for pay for performance measures. Both measures are evidence-based and accepted as quality indicators for SNF care. The risk adjustment is sufficient to deter providers from avoiding certain types of patients who might lower their quality scores. I'm going to say more about risk adjustment in a minute.

The measures do not require any new data and most providers can improve on them. The measures reflect the broad goals for most SNF patients, to improve enough to be discharged back to the community and to avoid a hospital readmission.

Paying for performance using potentially avoidable hospitalization rates as a measure is also one step in the path of holding multiple providers accountable for reducing the number of unnecessary hospital readmissions. It would also complement other policy ideas the Commission has

discussed, such as bundling payments around an acute hospitalization and would align incentives across providers to reduce avoidable hospital readmissions.

We evaluated two technical aspects of the measures, the risk adjustment and -- given the low Medicare shares in many SNFs -- the annual number of cases needed for stable estimates. The issue of risk-adjustment came up at last month's meeting when Bill raised a question about whether the measures adequately accounted for patients who were unlikely to improve. Adequate risk adjustment is key to ensuring that providers aren't penalized for treating certain types of patients.

You may remember Dr. Kramer's presentation from this past spring when he discussed his work on the factors contributing to changes over time in the community discharge and rehospitalization rates. In that presentation, he discussed the risk adjustment method. It includes 26 case-mix indicators, including diagnoses and measures of physical and cognitive function. Measures of physical and cognitive function are strongly associated with having been a nursing home resident and adjust for the likelihood that a patient will be discharged to the community.

Dr. Kramer described the risk adjustment as robust because it explained 64 percent of the variation in community discharge rates and 54 percent of the variation in rehospitalization rates across facilities. Because the models are good predictors of whether patients will be discharged home, facilities are not penalized if they treat the patients who are unlikely to improve.

Given the small Medicare shares in many SNFs, we also evaluated the number of cases a SNF would need to care for during the year so that the measures were stable. We found that a relatively small sample size was needed -- 25 cases a year -- and that would exclude about 10 percent of SNFs that treat less than 1 percent of stays. This attrition rate is a lot smaller than the almost 50 percent of stays that are currently excluded from the publicly reported measures that rely on a second patient assessment.

The two measures would form a basis of a starter measurement set that would be added to over time. Once patient assessments are conducted at discharge for every patient, measures that capture changes in patient condition should be added to the starter set. Any outcome measure would need to have adequate risk adjustment so that SNFs are

not penalized for taking complex patients or patients who are unlikely to improve. Measures to consider adding are improvements in physical functioning and pain management.

MedPAC has supported the idea of having an entity vet the performance measures so that the pay for performance programs are credible, efficient, and effective.

Because good measures are available, we think that Medicare payments should be linked to patient outcomes. This brings us to our second recommendation. The Congress should evaluate a quality incentive payment policy for skilled nursing facilities in Medicare.

Consistent with our design principles, the program would be designed to be budget neutral and therefore would not affect program spending. The recommendation should improve quality of care for beneficiaries. It would raise or lower payments for individual providers depending on the quality of care that they provided.

The second quality related topic considers the publicly reported SNF quality measures. CMS currently reports five quality measures for short stay post-acute patients on the Nursing Home Compare website. Experts have raised a host of problems with the measures and, because of

these, we've used the community rates of discharge and potentially avoidable rehospitalizations to gauge the quality of care furnished in SNFs.

There are several problems with the publicly reported measures. First, the current measures do not capture key goals of care for most SNF patients, to improve enough to be discharged back to the community and to avoid an unnecessary rehospitalization.

Second, because SNFs are not required to conduct patient assessments at discharge, there is a systematic bias in the measures because about half the patients are not included in the measures. They don't stay long enough to have a second assessment.

Third, the patient assessment questions ask about the care during the past 14 days, which can lead that the measures can reflect care that was provided during the preceding hospitalization.

Another complications is that assessments are not consistently conducted at the same point in time during the stay so that differences in quality scores may be the result of when the assessments were conducted rather than differences across patients.

Finally, the definitions in these measures are problematic. The pain measure is narrowly defined and confusing. The pressure sore measure was found to not be valid and the delirium measure is nonspecific and misses a large share of patients with the condition. Reflecting the measurement problems, CMS does not intend to include these measures in its pay-for-performance demonstration. Revisions to these measures should be evaluated by a panel of quality experts who consider the relevant literature and the reliability and validity of alternative definitions for these measures.

Reflecting the availability of alternative SNF quality measures and our concerns about the current publicly reported ones, our third recommendation reads that to improve quality measurement for SNFs, the Secretary should add the risk-adjusted rates of potentially avoidable rehospitalizations and community discharge to its publicly reported post-acute measures. It should improve the definitions of the pain, pressure ulcer and delirium measures. And third, require SNFs to conduct patient assessments at admission.

This recommendation does not affect program

spending relative to current law. The changes would result in more information being available to beneficiaries and their caregivers and make the information that is currently reported more accurate. For providers, it would support their quality improvement efforts. The increased provider administrative burdens associated with conducting assessments could be minimized if the day five assessment was replaced with one done at admission, and if the discharge assessment included only a few key items. CMS would need to incur modest administrative costs associated with adding the new measures to its publicly reported set and developing a pared back instrument for use at discharge.

With that, I'll end my presentation.

MR. HACKBARTH: Thank you, Carol. Well done. Questions and comments?

DR. SCANLON: Thanks very much. I think that the work that Carol has been leading here has really moved us forward very much in this direction. I'm particularly excited about knowing that in March we're going to hear about some possibilities in terms of reforming the payment, since this has been a problem I think we've worked on for about eight years. The notion that there may be something

at the end of the tunnel is really very reassuring.

The other thing is the idea of using the payment system to try and influence the quality of care in SNFs and nursing homes, is also something that I'm very supportive of. In the chapter you cite a GAO report, which is like the 26th or 27th of those reports, talking about quality problems in nursing homes. While there are other mechanisms that have been talked about in terms of trying to improve quality, if we can use payment that would be just one more tool and hopefully an effective tool.

Supportive of the principle though, I guess I feel that we're not right yet at the point where recommending to the Congress we have a national program in terms of pay for performance for SNFs is the right place to be. We really need some more testing of ideas before we can implement something that we can feel comfortable about. I think I've said this before, I have this continuing fear that when the government does something and it turns out to be wrong it's very hard to reverse it. So you'd like to know as much as possible before you start something on a national scale.

Let me make comments about our two measures as well as the risk adjustment. I appreciate your response in

terms of my question from last month and I guess maybe my name should be Thomas and I can say I'm a doubting Thomas here. I still have my concerns, which is that risk adjustment and our testing of risk adjustment in part depends on the context. Right now we sort of have a situation where there wasn't an incentive for the homes to select on the criteria that we're concerned about, namely are they going to be people that are more likely to be rehospitalized? Or are they people that are less likely to be discharged to community?

From my experience in the past, providers information about a particular patient so vastly exceeds what we know in the public sector or as a payer that their ability in some ways to select or to identify differences among patients is so much greater that our risk adjustment methods pale in terms of their ability to make the right decision.

I say this in particular with respect to nursing homes because having been around when what we called case-mix systems for Medicaid reimbursement were introduced in states, to see the shift in behavior on the part of nursing homes in terms of how they screened potential residents, the

information they gathered from hospitals or from families before they admitted somebody, that they really do make an effort to identify who's the best resident in terms of the incentives that we face.

This would be one part of trying to test this, which is are the risk adjustment methods robust enough when we change the incentives for behavior, which a pay-for-performance system would do?

With respect to the two measures themselves, there is also an issue of the ability to risk adjust in an appropriate way and to control the measurement of the outcomes.

On the rehospitalizations, there's kind of like a reverse side of that which is inappropriate non-rehospitalizations, which is the idea that we've created an incentive to keep a person in a nursing home or in a SNF, but do we keep them there to their detriment when they should have been appropriately rehospitalized? You say that and you say aren't we going to know the consequences of that? A very large number of people in nursing homes die. And this is an expected outcome. So if you see someone die, that is not an indication necessarily of the wrong type of

care.

In fact, the teaching nursing home program that was a demonstration program back in the late 1980s, early 1990s where they brought in and beefed-up the capacity of the nursing homes by having faculty for nursing schools as well as students. They kept people from being rehospitalized when they had developed significant acute conditions. More of them died. But that was going to be their outcome anyway. So it was not that they were getting poor care or anything. But there's a question of we're not talking about the same kind of situation where we can be confident that a change in health outcomes for residents when they're not rehospitalized is the inevitable is a benign sort of thing.

The other issue in terms of discharge to the community, the issues of difficulty in terms of defining exactly what we mean in providing safeguards there. Back in the late 1970s there was an experiment with pay-for-performance for nursing homes which was trying to encourage discharge to the community but wanted to make sure that discharge was meaningful, that people remained in the community and they weren't just inappropriately discharged.

That's more challenging than just discharging them. There wasn't any sort of behavioral response there. Whereas there was -- in terms of the nursing homes doing that -- there was a strong behavioral response in other elements of that demonstration.

So I think this is, again, something we need to explore. And it's more difficult to explore in today's world because, unlike the late 1970s, we have a more complex world of institutional or residential based long-term care. We have a million assisted-living facilities. We've got foster care. We've got continuing care retirement communities where they can deliver nursing home equivalent care in your unit. So all of these things, they kind of make the definition of community somewhat different.

I wouldn't want the circumstances of a particular community or a particular institution, say a skilled nursing unit of a CCRC, I wouldn't want that to dictate how a facility does in terms of performance. We want their performance as measured to reflect their care that they delivered as opposed to their opportunities.

That could maybe be handled with a different form of risk adjustment but it is a new concept, something I

think we need to think about.

I believe we would be better off, instead of making a recommendation to the Congress to say let's enact a national program, to piggyback on the CMS demonstration. We talk in the chapter about differences between what CMS is going to do and what we would have done if we had designed the demonstration. I think we should encourage them to move it our direction. We should encourage them to be expeditious about implementing this and evaluating it quickly.

And frankly, we should be their watchdog in terms of are they doing it? Are we learning as much as we can from it? It's not that we want to walk away from pay for performance for this type of care. It's just that we want to make sure it gets done as well as we can as quickly as we can. And I think passing it on, at this point, to the Congress is not necessarily going to accomplish all of those goals.

Thanks.

MR. HACKBARTH: Carol, any thoughts that you want to share?

DR. CARTER: I have a few thoughts. First, in

terms of patient selection, I think everybody here would agree that risk adjustment is critical, that that doesn't go on.

The work that we've been doing with Urban is probably a much stronger vehicle than a pay for performance program with a small set-aside could accomplish. And that's why we're moving pretty quickly in that work, because trying to target payments to patients who require non-therapy services is going to help, I think, a lot in terms of nursing homes selecting certain types of patients versus others.

I feel like we have maybe a two-pronged approach to trying to make sure that nursing homes and SNFs don't select against patients. One is appropriate risk adjustment for the measures and the other are the SNF payment reforms that we will be discussing probably at the next session.

The second thing I wanted to make sure we keep focused on measures that are appropriate for the SNF population. I know that there are measures for nursing home patients but we are trying to talk about short stay patients here. So something like a discharge to community rate within 100 days probably is a better preventer of dumping

than a 30-day rate because if the average length of stay is 26 days, having a measure that at least captures within 100 days is, I think, helping to make sure that providers don't discharge patients prematurely.

In terms of risk adjustment, and I knew this question was going to come up. So I talked with Andy Kramer at least three times in the last month about this. His basic take is this is as good as it gets. This is a very robust risk adjustment method. It may not be what we want but he said it is well above the standard that has been used for other measures. So his statement would be that these measures are very robust.

DR. SCANLON: I wouldn't disagree that maybe it's as good as we can get. But the question is is it good enough? That's the test that I'm asking to be performed.

I think the other issue is that the people that come into a SNF as Medicare patient are not all short stay. Some of them are going to be people that were discharged from the nursing home to go to the hospital and come back after a three-day stay and be Medicare eligible again. Some of them are starting a long stay.

I think it's complicated by the fact that we have

these variety of residential settings today so that the discharge from the skilled nursing facility is not as clean-cut as quote "return to the community." Return to the community doesn't mean return to home. It could potentially mean return to another institution or transfer to another type of institution.

Now how we decide to define return to the community maybe deals with part of that. But we have to also think about the fact that in doing something nationally we are dealing with long-term care systems in different parts of this country that are incredibly variable in terms of how long-term care is provided.

In thinking about who lives in the community versus who lives in a nursing home, I did once work that compared Karen's state with Dave's state looking at the same cohort of people. In Karen's state, 50 percent of them were living in nursing homes. In Dave's, 90 percent of them were living in nursing homes. So you've got these dramatic differences in terms of what it's going to mean to be back into the community.

And that again -- and it's potentially a risk adjustment requirement.

DR. CARTER: You and I talked about that these do adjust for nursing home bed availability.

DR. SCANLON: Bed availability. But there's more to it today than there was back then.

It's this issue of let's explore these questions before Congress enacts a law. That's all I'm saying.

MR. HACKBARTH: I think the point you are raising, Bill, is a profound point, that surely we don't want to make things worse. In any change there is a risk of unintended consequences and the government does not work well in reverse. I think at one meeting you said it doesn't even have a reverse gear. So it goes forward very slowly and backwards not at all. This is not a pretty picture.

Having said that, a point that I often make is when considering whether a new proposal is a risk worth taking. And they all involve risk of various types. You need to compare that not to an idealized status quo but reality as it exists right now. You are way more expert than I in this area, because of your long GAO experience with it. But my understanding is the status quo right now on the quality of care in particular right now he is not all that great. So I worry about the cost of just being stuck

where we are and not moving ahead.

That's not an answer. It's just the other side, something to be put in the other tray on the scales that we're using to believe these things.

DR. SCANLON: And I did consider that because I have certainly spent an incredible amount of time looking at the quality of nursing home care. But this gets to that issue that Medicare represents 10 percent of nursing homes on average. This morning we had this discussion about distributions. And that is the critical thing because it represents an even much a smaller share of some facilities.

And the question of whether we're going to actually have an impact on that quality is a very problematic. The quality problem that you're referring to I think is much more widespread and there needs to be other ways to address that.

I think using reimbursement to try and reinforce some of that is potentially a good thing. But I guess it's not a good enough thing to motivate me to want to move so quickly. That wouldn't be my motivation.

MS. HANSEN: A couple of comments and then a question.

I, first of all, really appreciate the level of work that's gone into this. And plus, you are including some of the questions that we had last time. I know I brought up one of the aspects about the differentials between the for-profits and the not-for-profits. So I appreciate that that's going to be looked into.

And Bill, I just think that your comments have been very important in terms of the context of change and the fact that right now a small percentage oftentimes of the population is Medicare only. Which brings the other side of it, with the fact that again this is about the Medicare program. But that bricks and mortar of the facility serves the Medicaid population, as well.

I just wonder if we would be informed by some of the pay-for-performance efforts that are happening on the Medicaid side as well, and be able to kind of have that addressed somewhat in the text, just so that again -- much as you were talking about Medicare and commercial synergistically moving along, if there's some states doing Medicaid pay for performance that we also try to look at that synergistically.

And then the question I had was relative to the

points about MDS and how these elements of pressure sores and pain are not necessarily accurate. I guess I don't know whether this is a rhetorical question, but if that is the case and so much time is being spent in facilities doing this tool, do we know whether or not there is some major effort underway to tighten this up so that it's more accurate.

And then finally a closing comment is as we look at this, and to take into account, Bill, that we have now assisted living facilities, we have board and care homes types of places where people go back to. I think I've brought this up before, and this is a more futuristic thing, is whether or not at some point looking at the outcomes of money following the person or outcomes following the person rather than by facility or touching the home health agency level, the skilled facility. But just what happens to the trajectory of a person and all the money as well as the services that follow that person.

But it just strikes me as we talk about different physical structures that people go to that the reality is the money is following them along with the services there.

But the MDS question, I guess is the last one.

DR. CARTER: The MDS has been under revision for I think two to three years. There is a draft, 3.0. We're now on the 2.0 version. The draft 3.0 version is on the website. I've looked at it pretty extensively.

There are major changes to the three measurement areas that I've discussed, the pain, pressure ulcer, and delirium. The sections are much more expanded. The measures are much more specific. And the look back periods are narrower, which I think will actually address a lot of our concerns with these measures.

That's still in draft and CMS has had a technical panel review these changes. It's been piloted. So I think they've done a really good job of trying to revise this tool because there have been problems with the accuracy of this tool.

MS. BEHROOZI: I have not spent not even a fraction of the time that you have, Bill, thinking about this. But in the short time I've been here I've thought a lot about -- as Carol knows particularly, and I guess the rest of you do -- that the issue of the correlation between staffing and not just how much staff you have, but the types of staffing that any institution has that Dr. Kramer had

found so highly correlated. And it's in the paper that it's one of the three factors, besides facility type and for for-profit or not-for-profit status, that's highly correlated with these two outcomes measures.

Jack actually asked last time, and I know the question is kind of a standard question, if you've got the ability to measure the outcomes why do you need to also do that structural measure? It's just occurring to me listening, Bill, to your discussion about the unintended consequences might be in terms of people gaming the outcomes by selecting patients. That's one of the reasons I think -- I think I'm learning this as I'm paying attention -- to add a structural measure so that -- so it mitigates against the unintended consequences of a provider with a motive to enhance their bottom line simply going for the patients that aren't caught by the risk adjustment that help them enhance their bottom line.

I think that there are various other reasons why structural measures are incorporated into quality assessments, whether it's the CMS demo project that has staffing levels at the same level of value -- 30 points is accorded to staffing levels as 30 points is accorded to rate

of rehospitalizations. And in other areas, in the work comparing MedPAC's visions for quality measurement system against CMS's, again we list among the things that we value -- at least in certain circumstances -- those kinds of structural measures like staffing.

So I would again urge, particularly -- I think it's somewhat related to the topic that Bill has raised -- considering that staffing level issue.

DR. KANE: I have really more I guess questions and then one comment about what Bill was saying about Medicare being the tail that might be wagging the dog because it's only 10 to 12 percent of the total.

One is it seems like it's the most attractive 10 or 12 percent from what I've heard. So these SNFs seem to want Medicare patients, especially the ones with high case-mix and rehab possibilities. To me that seems like an opportunity rather than a negative to implement something because right now these are patients that they want. And maybe if you want Medicare patients, maybe that's a good time to implement something that's a little harder for the SNFs to do than would otherwise be...

I'm not that worried that the 10 percent that are

the most sought after, if they come in with more strings attached, that the nursing homes will want to stop going after them. I would think particularly the Medicaid dominated ones would want to go more after the Medicare patients, which might be good in terms of improving the quality. I guess the tail wagging the dog argument is just too small a piece of the nursing home business. I don't agree that it's the most attractive piece.

So maybe you could answer that before I go on to my other point.

DR. SCANLON: The issue is there are no strings attached after you've introduce this. Look at the average margins. You can forgo the pay for performance bonus, still make good money, and not provide any additional service.

DR. KANE: I don't see how that stops you from saying we're trying to up the conditions by which you get these patients though. I mean, *w*hy would that stop you from saying --

DR. SCANLON: The issue is that if somebody wants to compete for the pay for performance bonus, they have a choice. They can compete through providing better care or they can compete for it by selecting patients.

DR. KANE: I think that's difficult than the 10 to 12 percent.

DR. SCANLON: No, it's the issue of what are you going to do? Is this going to be worth it for you to change your behavior in terms of an institution? And that's where the 10 or 12 percent over the 2 percent or the 3 percent, which is the reality in some facilities, is going to play a role. And remember, it's not just the Medicaid and Medicare patient or resident that we're talking about. There's the private pay person.

There's also a concern I didn't raise, which is the whole issue of nursing homes are a little bit like -- think of them as hotels: one star, two star, three star, four star. And you pay according to the number of stars. You get services according to the number of stars. And so therefore there is this potential that when we start to reward people that can do a better job, they are the more expensive places. They're not going to be available to everybody across the country. We're not talking about a level playing field in terms of competition.

And the people that are at the bottom are not going to be in a position where they're going to want to

bother to compete.

DR. KANE: You're actually making my same arguing about the hospitals but we won't go there, about the weakest ones are least able to fix themselves.

I'm not sure I buy the argument. I guess the other piece in that relates to the same question. Okay, 10 or 12 percent are in SNF status. But how many of those SNF patients are actually discharged to long-term care in the same facility?

We keep talking as though they're completely separate patient populations. But my sense is a lot of the people that you let in on the front end then become your long-term care patients. We never really talk about what proportion -- I know 30 or 35 percent go back to the community, 17 percent are rehospitalized. What about the other half? And how many of those go on to become your long-term care population? In which case, who you bring in does become your whole population. And you do have an incentive to try to get -- you do have an incentive to respond to the quality issues.

They're not all separate populations. They're all the same people just moving through, aren't they? Or

staying in place?

DR. CARTER: It's a pretty small percentage of SNF patients that get discharged to a nursing home, like less than 10 percent.

DR. KANE: When we say discharged, are we talking about people who stay in the same facility and move into the long-term care component?

DR. CARTER: Yes. And it's less than 10 percent.

DR. KANE: That would move it up to about 20 percent, the ones who come in stay. No, it's less than that.

So where do the rest of them go? Because only 30 to 35 percent go home or go to the community?

DR. CARTER: I haven't looked at that.

DR. KANE: That's a lot of people who don't go anywhere.

DR. CARTER: Some go to a second --

DR. KANE: Do that many of them die in SNF?

DR. CARTER: No, they have other -- some go on to other kinds of long-term care facilities. Some go onto a different SNF. There's sort of a whole -- any provider that you would expect, they go to.

DR. KANE: It would just be helpful for me to understand that we're talking about here because I don't get a sense of what happens to those SNF people. And if half of them die, I don't really understand where they're going.

DR. SCANLON: I don't what it is today, but historically some of the poorest data that we had were on discharge status of SNF patients.

DR. CARTER: That is a problem.

DR. KANE: So maybe we should recommend we get better data. Because I think it is hard to make these kind of decisions without knowing what the end result is. And 35 percent going home doesn't tell you where the other 65 percent go. And it would help me understand how much the tail is wagging the dog if I knew how many of them actually them ended up either sticking around or going to another SNF that has to deal with them.

DR. STUART: We've done some work on using the Medicare Current Beneficiary Survey to address just this question. And I think it's a very important question because if you're going to have a patient that is going to be influenced or that the facility is going to influence for a particular patient, that patient stays. Or if the patient

goes to another nursing home and is influenced by that nursing home's policy, that's really important.

The figures that we came up with were much higher. They were close to 50 percent for people that ended up -- now I can't tell you that it was from a given SNF into the nursing home part of that same facility. But the people that we talked to about these rates suggested that it was pretty rare for somebody to be discharged physically from one SNF into another nursing home. That it was much more common to stay within a nursing home.

I think one of the problems that we have is that Medicare doesn't have a good way to track these people because once they stop being SNF covered, then Medicare doesn't care. They're just paid for Part A and for other Part B services. So this is something that I'd suggest you take a look at.

DR. KANE: I think there's another reason take a look at that is that even though they're no longer taking Medicare benefits in their long-term care -- they are Medicare eligible patients and we should be knowing what's happening to them.

DR. CARTER: They are probably receiving Part B

services.

DR. KANE: And they might end up back on Part A if they don't getting good care in the long-term care. I still worry that we don't know what these people are or who they are.

DR. CARTER: This is part of a longer analytical agenda for us is to understand both differences in patients in different types of facilities, which Jennie alluded to a little while ago, but also the churning of patients and who gets readmitted, who goes on to be turned into a long stay patient. We haven't looked at that at all.

As Bruce mentioned, it's hard because it's hard to track patients over time when then you're going to be relying on Part B claims experience to understand where the patients are after their Part A stay eligibility ends. I think the folks at Colorado are just starting to put together nursing home stays with SNF stays so you have a better longitudinal view.

DR. KANE: If we look at episodes are we going to capture that long-term stay?

DR. CARTER: We can't unless we had Medicaid claims data. For the stay portion, we would know that they

were getting Part B therapy services or physician services. But we don't have the stay portion in at least the Medicare claims stream.

DR. SCANLON: Your recommendation three, in part, is going to deal with that because you're asking for an assessment which would create an MDS record at discharge from the SNF status. And then presumably that's going to tell us where this person is going at that point in time --

DR. CARTER: The MDS has that.

DR. SCANLON: -- and then the MDS can capture it. But right now we have this limb period between the periodic MDS and the next one. And we don't know what --

DR. CARTER: We lose half of them because we don't have SNF -- right.

DR. STUART: I don't want you to recreate the wheel because the MCBS is really good on this because it has a special file which is a resident timeline. And so they actually identify each of these changes in status. It's not perfect. But it will let you get there a lot quicker than if you try to do it on your own.

MR. HACKBARTH: Other questions or comments on this? Jennie, the last word.

MS. HANSEN: Just a small one relative to capturing the data. I just was noting to Jack that even though the data amount is small, any of the PACE projects around the country capture A, B, D, the whole works. So you actually will track this. When people stay on the average three-and-a-half or four years, you could do a smaller subset just to get a sense of it. It's one place where we have both the ICD-9s and the pharmaceutical costs, even the lab cost. All of that is captured on every single person.

MR. HACKBARTH: Let's turn to the recommendations and do our votes. On recommendation one, all opposed? All in favor? Abstentions?

Number two, all opposed? In favor? Abstentions?

Number three, opposed? In favor? Abstentions?

Okay, thank you, Carol.

Next is home health. And you can start whenever you're ready, Evan.

MR. CHRISTMAN: Next we're going to do home health. As you may recall from the last meeting, the adequacy indicators for home health are positive for the most part. Almost all beneficiaries live in an area served by home health agencies. Access is nearly universal, 99

percent of beneficiaries live in an area served by one home health agency and 97 percent live in an area served by two or more home health agencies. The number of agencies continues to increase. We're still below the peak of 11,000 agencies that occurred in 1997, but in 2007 the number of agencies increased by about 400 to a total of 9,300. The trends in growth that we've seen in recent years continues with most agencies being for profit and a few states accounting for a significant share of the growth.

The volume of episodes and the share of home health users -- the share of fee-for-service beneficiaries that use home health has grown faster than the overall Medicare beneficiary population. For example, the share of fee-for-service beneficiaries that use home health grew from 7.1 percent in 2002 to 8.1 percent in 2006. On a per capita basis, the number of episodes per beneficiary has grown by 25 percent since 2002.

On quality, we've seen a continuation of the trends since the measures were established in 2002. On the five functional measures, there continues to be consistent but small annual gains in functional status among home health beneficiaries every year. On the adverse event

rates, those rates have remained unchanged. The adverse event rates are hospitalizations and ER usage. The one exception is that in the last year we have seen a 1 percentage increase in the rate of rehospitalization.

And then finally, in 2006, we found that home health agencies had margins of 15.4 percent.

Before I take you through the margins for 2008, I just want to remind you of two policy changes that we have to include in our modeling. The first of these is a payment adjustment to account for changes in coding practice. CMS found that about 90 percent of the change in the home health case-mix between 2000 and 2005 was due to changes in the coding practices of home health agencies and not changes in patient severity.

As a result, they concluded that the current case-mix overstates severity by about 11.8 percentage points. To account for this, CMS is reducing the base rate in the next four years to lower payment levels to account for this coding change. The adjustment will be about a 2.7 percent reduction in each of the next four years. Our margin estimates will include the impact of these base rate adjustments.

Also in 2008, Medicare will implement a new system of resource groups. The number of resource groups will approximately double under the new system from 80 to 153. The new system eliminates the single therapy threshold under the old system and replaces it with a system of multiple thresholds that gradually increase payment by smaller increments for additional therapy visits.

They've also updated the case-mix weights to reflect 2005 data on the number of services beneficiaries in each resource group use.

Our analysis indicates that these refinements will have a modest impact on the accuracy of the payment system. I can walk you through that during questions if you'd like to know more.

The other thing I would note is the new system significant expands the role of diagnostic coding in setting payment. And consequently we are assuming that the implementation of the new system will result in changes in coding practice in 2008 and will increase payments. I can provide additional information about this on questions, too.

With those policies, we'll turn to the payment changes for 2008. Home health agencies received a full

update of 3.3 percent in 2007. In 2008 they're going to get an increase of about a quarter of 1 percent. This quarter of a percent is the net impact of two payment adjustments. One, they get the full market basket update of 3 percent in 2008. But that's almost completely offset by the coding adjustment that I mentioned on the previous slide, where they're reducing payment for coding changes that occurred between 2000 and 2005. So 3.0 with a 2.75 negative adjustment results in a base rate increase of a quarter point for 2008.

In terms of costs per episode, we saw that it's still low. We observed a rate of 2.7 percent in 2006, which is low relative to other providers but it's higher than what we've seen previously with this payment system.

With these assumptions, we estimate the margins for 2008 at about 11.4 percent.

To recap, I would note that again access to care is nearly universal with most beneficiaries having a number of providers available. Quality is improving on most indicators. The supply of providers continues to grow. The share of users continues to increase. And the episode volume continues to increase faster than the growth of the

Medicare population. Cost growth continues to be relatively low and the margins again are 11.4 percent.

With this information, we now turn to a draft recommendation for 2008. This recommendation reads the Congress should eliminate the update to payments for home health care services for calendar year 2009. In terms of spending, this would decrease spending relative to current law by $250 million to $750 million for 2009 and $1 billion to $5 billion over five years. We would expect this would have no major implications for beneficiaries and providers. That is, we expect that beneficiaries would continue to have access to care and providers would still be willing to supply it.

I now turn it over to you.

DR. STUART: Thank you, Evan.

I have a question about your adequacy measure. Maybe you can help us understand this industry a little better because when you talk about most areas of the country being served by one or two or more home health agencies, now if the home health agency is a mom and pop outfit, that's going to give you a very different sense of adequacy of access to service as opposed to if it's a large hospital-

based home health agency.

So could you talk just a bit about the structure of the industry and whether the size of the agencies would have an influence on accessibility?

MR. CHRISTMAN: You're right. The industry does vary a lot in terms of size of the individual agencies. Around 10 percent but a growing share of agencies are part of the large publicly traded home health firms like Gentiva and such. And that share is growing. Those firms are very aggressive about acquiring already operating agencies.

This is the challenge we face in that the size of these home health agencies is variable and it's difficult to measure what a home health agency's capacity is because some may have a different staffing ratios, they may use contract staff. We don't collect information on staffing so we don't know.

But I think what we have observed is that for many years now the Commission has reported the same numbers I just gave you about the 99 and the 97 percent. And the number of agencies has continued to grow. It's been concentrated but that doesn't mean that all the growth has just been in a few areas.

So I think in terms of more beneficiary level, beneficiary measures of access, the CAHPS fee-for-service survey used to ask questions about home health access to care. The last year they did that was 2004. As I recall, the number of beneficiaries who were able to find home health when they needed it was somewhere north of 85 percent. It's been a while since I looked at those numbers. But that's probably the other measure I could give you besides the home health compare measure.

When you start to talk about it at the local level, there may be other factors afoot. But since we've been doing this adequacy analysis for the last couple of years, we've seen rising volumes and very high measures of availability and haven't seen anything that suggested a system level issue.

DR. MILLER: I was just going to make the point that you actually got in at the end. You also -- I don't like to confuse service volume with access, but you also see that on top of the other points. But he got it in right there at the end.

MR. HACKBARTH: So Bruce, one of the characteristics of this sector is diversity. Is there a

policy implication that you were getting with your question?

DR. STUART: I was just trying to get a better handle on this. In a previous meeting Bill was talking about the difficulty in trying to understand what this service really was all about. So if we make strong statements about access is adequate, that implies to me that we may know more about this than we do. Or we're saying that we know more about this service than we do.

MR. CHRISTMAN: I think one thing we have with the home health that is, I think, advantageous is the numbers I use come from Home Health Compare. They more or less look at things as ZIP code level, which in some areas is pretty tight. It's not a perfect measure.

I guess what makes me feel comfortable about the usefulness of that access measure -- and I hope I spelled this out and I'm going to say it again -- we look at the areas where beneficiaries live. We pull that from the master beneficiary database. And then we compare where home health agencies reported operating by ZIP code in the last year. When we did that in the last year, 99 percent of beneficiaries lived in a ZIP code where a home health agency reported operating.

DR. REISCHAUER: I wonder if adequacy is the right term, as opposed to more adequate than it was the last time we looked. In which case what you could do is look at services delivered by ZIP code, county, whatever as a percent of age-adjusted Medicare beneficiaries in that area.

Now if it went down, you couldn't say things are worse because people might be healthier. But if it went up everywhere, you would be able to say definitively it's better than it used to be. But you have no measure of what is needed and you don't even know what we're providing when it is needed. So in a way, adequacy is impossible to find.

MR. EBELER: I'd like, Even, just maybe to ask you to describe a little bit about what you talked about in the chapter and didn't include in the presentation on the long-term. I guess when I look at the numbers, as I said at the last meeting, even a freeze appears to result in an extraordinarily generous payment level, especially when compared with the constraints we're dealing with in physicians and other providers. I recognize that a freeze is about as far as we can go.

One of the answers I think was looking to future refinements in the system we may end up something that we're

all more comfortably. Would you say a little bit about where we can do with those future refinements?

MR. CHRISTMAN: Sure. Again I just would note that 2008, they are implementing a new system. It's a big change for the industry. One of the things we have found in looking at estimated payments under even the new system, it still appears that episodes with significant amounts of therapy are still more profitable than episodes that don't have them.

We didn't go into it in this presentation but in the chapter there's a discussion of how, especially in the last year, therapy heavy episodes have become a significant driver of growth in home health volume. To the extent that beneficiaries are receiving appropriate services that shouldn't give us any pause perhaps. But the fact that we do observe that the margins on episodes with more therapy visits pay more -- are more profitable -- it creates an incentive that may draw some concern.

So one of the things I wanted to look at is what's creating this imbalance. And one possible candidate is that since this was an element in the old system -- the HHRG-80 system that they just finished using -- and it's present in

this new system as well, one issue we're going to be looking at is how they measure costs when they build these payment systems. The home health PPS is a little bit of an exception in that they don't really use the cost report data that much. They use estimated labor costs.

And so we'll be looking at that and taking a look at any other factors we can come up with that might shed light on this imbalance and possible refinements that will hopefully balance the incentives more evenly in the system.

DR. CASTELLANOS: I'd like to really ask a very naive question and it's a little out of context. But when we were voting on this, it's bothered me last time and it's bothering me this time.

We're going to vote to eliminate any update but productivity was this discussed this morning, which is efficiency. How is that reflected in this statement when we eliminate an update but don't mention anything about productivity?

MR. HACKBARTH: In essence, we've done market basket minus productivity minus some other X factor to get to zero. So multiples of productivity.

DR. CASTELLANOS: What you're saying is that by

giving no update that implies we should not encourage them to do productivity and efficiency? That's what productivity really is, isn't it? To encourage each to be a little bit more efficient in their practice?

MR. HACKBARTH: And the mechanism by which that happens is the price. We're saying the price ought to be squeezed here for two reasons. One, the margins are very high and to help bring those down. But two, by applying pressure for home health like everybody else, induce them to become more efficient.

DR. WOLTER: Just an observation, and I'm not an expert on home health by any means. But as has been brought up in the past, the hospital-based home health isn't captured, as well, in this database. Certainly in rural states -- I know in Montana what I hear from home health agencies that are hospital-based is they have much more of a struggle around their financial viability. I think we were the one state that had a net loss in home health agencies when we looked at the data last year.

So there is a rural flavor here that isn't necessarily captured here, I guess would be one possibility.

And then I had a question about the new diagnostic

categories, and it was similar to my questions around the MS-DRG behavioral offset. Jack has very patiently explained to me why that was logical to introduce with the new MS-DRG system but I'm going to have to come to Hawaii for a remedial lesson on that.

But if the new system is intended to better categorize patients, is there any chance that trying to make it budget neutral to the old system isn't necessarily the right thing to do? Or do we really believe that there somehow may be marginal indications for therapies that might get triggered or patients are selected who are more likely to need these new diagnostic categories?

It's been a little confusing to me and it was confusing to me with MS-DRGs also. Because the other option would be to just go with the new system and then use the update even in a negative way to deal with the overall margins.

MR. CHRISTMAN: Maybe I would begin with the comment that the intent of refining the case-mix is simply to account -- I'm sure Jack has been through this with you but I'll just mentioned it again -- a better measure of the relatively costliness of the patients. It's not intended to

adjust the overall level of compensation.

There was no sense that the average case-mix under the last year of the HHRG-80 was too low, for example.

You asked about the new codes and conditions and how that works. I would say that they really have not changed the methodology of the home health payment system in 2008. What they have changed is the number of severity groups. That was possible because they had a significantly larger population to study. When they built the original case-mix system in 1997, they had the population of 20,000 episodes to build off of. When they built the new system they used about three or four million episodes. So they were simply were able to detect more conditions as having a relationship with home health resource usage.

So the number of conditions is increased. A rough way of putting it is there were four major clinical type categories -- a number of ICD-9 codes associated with each category -- and now it's like 22. They are also accounting for secondary conditions, for example.

So it is a more sensitive system but the intent of it is to better account for the relative costliness of those patients and not necessarily -- their work was not intended

to be any kind of statement about the overall level of reimbursement.

MR. HACKBARTH: A case-mix system, by definition, is about how a fixed pool of dollars is allocated across different types of patients. So when you move from system A to system B, it should be budget neutral. You are, in essence, assuming the same population of patients.

When you move to year one of the new system if, in fact, there is a change in the type of patient coming in to the payment system because of a change in technology or something, and so you're getting a different type of patient pool in the first year of the new system than you have in the base year, then the new payment system might generate higher total payments through more accurate payment for the new more severely ill patient. That's not budget neutral. It's just setting the index values in the base year that is budget neutral.

Julian, Jack, anybody else, did I get that right?

MR. PETTENGILL: [off microphone] You're recalibrating on a single year set of data from one set to another. You haven't changed the case-mix or the mix of home health agencies. What you've changed is the way you

characterize it. So it should be budget neutral.

DR. WOLTER: That's helpful. I understand the theory, I guess. I was just trying to understand if a new system, in fact, captured a sense that the total population maybe overall had higher severity than we realized you would operate off of a different philosophy, then it probably isn't that. We're just capturing the relative patients somewhat differently and therefore we want to keep it budget neutral. So thank you.

DR. SCANLON: I just wanted to follow up on what Jack said. In terms of concerns over this, the average margins are astounding. So I can understand your reaction. But somewhat consistent with our discussion this morning about the need to think about what we're doing in different terms, the distribution even bothers me more. It was the fact that we have 25 percent of agencies, which is more than 2,000 agencies, earning more than 25 percent. That's the kind of thing that we need to be able to change our recommendations so that we start to distinguish differences in terms of within provider type, the behavior and experience of different kinds of organizations. That really is critical for us in the future.

MR. EBELER: We are in this constant tension between the need to think about very longer-term reform, but yet at a practical level needing to do updates, whether it's physicians where there's a constraint, or home health where it looks pretty generous. The reality is we do need to deal it with today. And allowing these kinds of margins to float out there forever, pending the millennium of reform, is something I just think you've got to confront. We can't do it this year but if the payment policy is refined next year -- which seems to me that's a good thing.

MR. HACKBARTH: Any others?

So the draft recommendation is on the screen. All opposed? All in favor? Abstentions?

Thank you, Evan.

Next is inpatient rehab facilities and Jim is going to lead us through that. Jim, you can go whenever you're ready.

DR. MATHEWS: Today we'll revisit the draft recommendation on the update to the prospective payment system for inpatient rehab facilities, or IRFs, that we present last month. At that meeting some commissioners expressed an interest in considering an update

recommendation distinct from the prior year's recommendation of plus 1 percent that we used as the discussion starting point last time.

Additionally, since that time, Congress has passed and the President has signed, the Medicare, Medicaid, and SCHIP Extension Act of 2007. This legislation includes several IRF-related provisions that have significantly changed the landscape for this provider type. We'll discuss this legislation in more detail in a moment.

Because of these factors, we have prepared a new draft recommendation for your consideration today.

Before discussing the Extension Act, here are just a few quick bullets by way of reminder of some of the key points of Medicare's payment system for inpatient rehab facilities. These facilities provide intensive rehabilitation services to beneficiaries who meet certain conditions.

To be eligible for Medicare coverage in an IRF, a beneficiary must need and be able to tolerate intensive rehabilitation for three hours a day. Additionally, they must present with a diagnosis in one of 13 specific categories, such as stroke, hip fracture, and brain injury,

among others.

Medicare established in PPS for IRFs in 2002. Medicare spending under the IRF PPS was $6 billion in 2006.

To receive payments under the IRF PPS, which are much higher than the PPS for acute care hospitals, inpatient rehab facilities must comply with the so-called 75 percent rule. This rule requires that a certain percentage of a facilities' patients must be admitted having one of the 13 defined conditions.

While the requirement had been in Medicare regulation since 1983, in 2002 CMS determined that less than 14 percent of IRFs actually met this requirement. As a result, CMS began to renew enforcement of the 75 percent rule on a phased-in basis beginning in 2004. Prior to the passage of the Extension Act, CMS was on track to require that 75 percent of IRFs' patients be in one of the 13 categories effective July 1st of 2008. The 75 percent rule has been a major factor in declining IRF volume since 2004. I'll discuss that in a moment.

The Medicare, Medicaid, and SCHIP Extension Act was signed into law on December 29th of last year. It includes several IRF-related provisions. First, it

eliminates the payment updates for IRFs for fiscal years 2008 and 2009 but delays the effective date of this provision until April 1st of 2008.

Second, it changes the 75 percent rule, rolling back the compliance threshold and setting it permanently at 60 percent and making permanent the use of comorbidities to count towards compliance with the rule.

Third, it requires the Secretary of Health and Human Services to study access to IRF care under the 75 percent rule, to analyze alternatives to the 75 percent rule, and to examine the costs and outcomes of rehabilitation care for conditions not among those specified in the rule.

Changes to the 75 percent rule will affect IRFs' costs going forward and we have changed our FY 2008 margin projection accordingly. We have also prepared a new draft recommendation for your consideration.

First, to recap some of the data we presented last time on adequacy of payments, you'll recall that we examined the factors on this slide in assessing payment adequacy. I won't discuss all of these factors in detail today but I will take a little time to address volume of services and

payments and costs, as these are most affected by the Extension Act changes to the 75 percent rule.

As you will recall from last time with respect to supply of providers and beds, we saw an increase in the number of IRFs after the PPS began in 2002 through 2004, when CMS renewed its enforcement of the rule. After 2004, we see a small decline in the number of providers and beds, consistent with expectations under the 75 percent rule, but nowhere close to the reductions in admissions of 10 percent per year on average that we saw over this time.

As you will recall from last time, there is some underlying variation in changes in the distribution of rural and urban facilities.

This slide shows a little more detail regarding changes in number of admissions and payments from 2002 to 2006. Most notable are the pronounced decline in the number of cases and the increase in payments per case that occurred between 2004 and 2006. This indicates that IRFs were refraining from admitting less complex cases, again consistent with the 75 percent rule. Many of these cases were hip and knee replacements, which had been highlighted in the rule.

As we presented last time, and as indicated in your paper, these reductions do not appear to constitute an access problem. While the 75 percent rule drove much of this volume reduction, changes to the surgical techniques used in hip and knee replacements also eased postoperative rehabilitation, permitting beneficiaries to receive rehab services in less intensive settings such as SNFs and through home health.

In 2006, the rate of use of rehab by fee-for-service hip and knee patients across all settings was actually higher than in 2004.

We'll move on now to quality of care. Recapping last time, as we discussed previously, even with the changes in admissions required for IRFs to comply with the 75 percent rule, IRFs were able to continue to increase patient functional ability. The slightly lower rate of increase in more recent years may reflect the increasing complexity of IRF patients. Staff anticipate examining changes in the quality of care and outcomes more closing in the coming months.

As we reported last time, hospital-based IRFs' access to capital is good but freestanding IRFs are in a

more precarious position. About half of freestanding IRFs are operated by two large national chains, the largest of which is still dealing with the effects of financial and regulatory difficulties that it experienced over the last several years. These difficulties may continue to affect its financial performance in a way that may hinder its ability to raise capital through private investment or obtain capital at market rates.

The second smaller chain is somewhat better positioned to access capital, but again at somewhat higher than market rates.

The remainder of freestanding IRFs are generally single entities or small chains. Most are nonprofit and roughly half of these are associated with the academic medical centers. The Extension Act may improve access to capital for freestanding IRFs by reversing the need to reduce admissions, which resulted in decreased revenues.

We'll move now to a discussion of IRFs payments and costs. The analysis of payments and costs leading to the 2006 margin estimate that you see on this slide hasn't changed, so we won't cover this ground in detail again. We estimate an aggregate margin of 12.4 percent for 2006.

Our projection of IRF margins for 2008 is another story, and I'll spend a few moments going over it. When we presented last month, we projected IRFs' 2008 margins would be likely 4.4 percent within a range of 2.7 to 5.7 percent. This projection was based on the continued implementation of the 75 percent rule through July 2008. We estimated that IRFs would have to reduce volume by an additional 20 percent to comply with the rule.

We believed that IRFs would not be able to shed all of the indirect or overhead costs associated with these forgone admissions. These overhead costs would therefore be distributed over a smaller number of remaining cases, making them more costly and thus impacting IRFs' margins.

Now that the compliance threshold is set at 60 percent, IRFs will not need to make any further reductions in their admissions or cost structures in order to comply with this rule. In the aggregate, IRFs are already compliant with the 60 percent threshold. Therefore, we are now projecting IRF's 2008 margins to be 8.4 percent.

To summarize then, many of our indicators of payment adequacy -- the supply of facilities, volume of services, quality, and access to capital -- are unchanged

from our presentation of last month. Access to care and IRFs' margins, however, have changed for the better as a result of changes to the 75 percent rule in the Extension Act.

With IRFs improved financial picture as a result of this legislation, we now believe that IRF margins in 2008 will be sufficient to absorb any additional costs in 2009. As a result, we are now submitting a new draft recommendation for your consideration, which is the update to the payment rates for inpatient rehabilitation facility services should be eliminated for fiscal year 2009.

This recommendation has no impact on spending, given that the Extension Act has indeed sent the IRF 2009 payment update to zero. Neither do we expect this recommendation to have adverse impacts on beneficiaries' access to rehabilitation services nor on IRFs' willingness to serve Medicare patients.

With that, I'll conclude the presentation and can answer any questions you may have in your discussion.

MR. HACKBARTH: Jim, could you help me reconcile a couple of points on page nine, slide nine? You're talking about access to capital being mixed, freestanding IRFs may

be facing difficulty accessing capital. And then on the table on page 10, for 2006 the freestanding have actual margins of 17.9 percent, much higher than the hospital-based. Can you help me reconcile those?

DR. MATHEWS: Yes. Mostly under the access to capital discussion, I'm referring to the financial position of a couple of publicly traded companies and their ability to procure financing for capital improvements, new construction, upgrades to existing construction. Given the situation of these companies, it's quite likely that they will not be able to have ready access to capital either through private investment or through private lending at competitive rates.

MR. HACKBARTH: Is that because of developments in the credit market? Or is that because these particular freestanding chains are doing less well than freestanding, in general? If in 2006 the average margin was 17.9 percent, you'd think that that would support reasonably good access to capital. So that's the piece of the picture that I don't understand.

DR. MATHEWS: Some of it did reflect the larger credit market. Some of it did also reflect, until very

recently, analysts expectations of IRFs need to reduce admissions to comply with the 75 percent rule had that gone to it's bitter end.

So I can't say with certainty that they would still have as difficult access to capital after the passage of the Extension Act as might have been projected a month ago.

MR. HACKBARTH: Okay, thank you.

Questions, comments?

DR. MATHEWS: It's getting to be a trend.

MR. HACKBARTH: Hearing none, we're ready to vote. Could you put the recommendation up, Jim?

All opposed to this recommendation? All in favor? Abstentions?

Okay, thank you.

For the people in the audience, for those who may be attending their first meeting, you should be aware that for all of these update recommendations we've had multiple discussions already. So people have had opportunities to ask questions, look at the data. So this is the last step in the process, not the first.

Now we're on to long-term care hospitals. This is

the last of the update presentations.

MS. KELLEY: Good afternoon.

Today I'm going to highlight some relevant portions of the Medicare, Medicaid, and SCHIP Extension Act, which made some important changes to long-term care hospital payment policy. Then I'll review the analysis of payment adequacy for LTCH services that Craig and I presented at our last meeting. And finally, we have a draft update recommendation for you to consider.

First, I wanted to answer some questions that were raised to last month's meeting.

Nancy-Ann asked about CMS's progress in developing patient and facility criteria for LTCHs. Jack, you were interested specifically in the question of clinical conditions for treatment. We discussed this a little bit last month but we have got some new information to share.

As you know, last year CMS convened two technical expert panels to help determine the feasibility of facility and patient criteria for LTCHs. At the most recent TEP, held in November, small groups of clinicians from LTCHs, acute care hospitals, IRFs and SNFs used case studies to identify patient populations and discussed the types of

resources needed to treat these patients and the relative costliness and outcomes of treating them in LTCHs versus alternatives sites of care.

Regarding facility level criteria, there was general agreement among the TEP members that LTCHs need a critical mass of patients with the targeted conditions -- for example, ventilator dependence -- to ensure that providers had adequate experience treating the conditions. This was something that Nick mentioned last month, as well.

If this is the case, then the proliferation of LTCHs in some areas of the country might be cause for concern because an LTCH in an area with a lot of other LTCHs might not able to generate that critical mass.

Regarding patient criteria, TEP participants agreed that the most consistent identifying future of critically ill patients is probably the need for intensive nursing care. For example, LTCHs and acute care hospital step-down units often have a registered nurse to patient ratio of one to four or five, compared with a typical ratio of one to 12 on an acute care medical/surgical floor.

This finding underscores a crucial point. There may be no such thing as an LTCH-only patient. We might be

able mail to identify patients who are candidates for LTCH care but those patients generally can be treated appropriately in other settings, as well, particularly acute care hospitals and some SNFs. Of course, this has implications for our payment systems, as well.

Jay, you asked how Medicare Advantage plans used LTCH care. I spoke with representatives from a few national organizations and learned that for managed-care plans, LTCHs are not the provider of choice in most markets. Plans find that in most cases the care is too expensive and the benefit is too open-ended. They report that staying in the acute care hospital longer or transferring to a SNF if a suitable facility is available is preferable for many patients. The representatives I spoke with said that when they approved transfers to LTCHs, it's primarily for patients who are ventilator dependent in markets where SNFs are not equipped to wean patients and for patients who require very complex medical care. One representative gave the example of a dialysis patient who also need needs hyperbaric oxygen treatment. If admitted to a SNF, that type of a patient might spend most of his or her days being transported to different facilities receiving the care that they need.

So in such a case, an admission to an LTCH would be more appropriate if remaining in the acute care hospital was not an option.

Plan representatives reported that they faced a lot of pressure from acute care hospitals, particularly in certain regions of the country, to move patients out of the hospital as quickly as possible, but that in many cases if the patient can stay a few more days in acute care they are then stable enough to be appropriately transferred to a SNF. The representatives we spoke with reported that acute care hospitals with co-located or co-owned LTCHs were more aggressive in pushing for discharge to LTCHs.

Finally, you'll remember that about 20 percent of Medicare fee-for-service admissions to LTCHs are direct admits with no previous acute care stay. Plan representatives told us that they found those kind of direct admissions were almost never appropriate and therefore were almost never approved.

Finally Mitra, you asked about CON states and how they evaluate the need for new LTCHs in their states. I looked at the process in a few of the states and Florida provides a good example of what goes on. Florida evaluates

the need for new LTCHs by considering evidence that high acuity patients place a burden on area acute care hospitals through extended stays or that high acuity patients are receiving inappropriate care leading to poorer health outcomes, acute hospital readmissions, or higher mortality rates. Florida appears to have the expectation that LTCHs should serve more than the immediate area, that they should act almost as referral centers for the most medically complex areas in a wider catchment area.

Turning now to the Medicare, Medicaid, and SCHIP Act, it included several provisions relevant to LTCHs. First, the Act changes the definition of LTCHs to include some of the facility criteria recommended by MedPAC in 2004. In addition to meeting the conditions of participation applicable to acute care hospitals, LTCHs must how have a patient review process that screens patients both prior to admission and regularly throughout the stay to ensure appropriateness of admission and continued stay.

But the Act does not specify the admission and continued stay criteria that should be used. You'll recall from last time that the admission criteria currently used by QIOs does not distinguish whether a patient needed LTCH

care, as opposed to acute hospital care. LTCHs are now required to have an active physician involvement with patients during their treatment with physicians on site on a daily basis to review patient progress and consulting physicians on call and capable of being at the patient's side with a period of time to be determined by the Secretary.

LTCHs must also have interdisciplinary treatment teams of health care professionals, including physicians, to prepare and carry out individualized treatment plants for each patient.

The Act also rolls back the phased-in implementation of the 25 percent rule for hospitals within hospitals and satellites. As you know, beginning in fiscal year 2008 hospitals within hospitals and satellites could admit no more than 25 percent of their Medicare patients from their host hospital each year. The Act rolls the threshold back to 50 percent and holds it at this level for three years. In addition, the Act prevents CMS from applying the 25 percent rule to freestanding LTCHs for the next three years.

The Act also makes changes to CMS's policies

regarding short stay outliers. You'll recall that beginning last July CMS applied a more stringent standard to the shortest stay outliers, called the very short stay outliers, which have an average length of stay that is less than or equal to the average length of stay for the same DRG at acute care hospitals plus one standard deviation. The Act prohibits the Secretary from applying this new rule for the next three years. So very short stay outliers will be treated the same as the other short stay outliers.

The Act also reduces aggregate payments for fiscal year 2008 by implementing a zero update for discharges occurring during the final quarter of the fiscal year. It provides $35 million in fiscal year 2008 and 2009 for expanded review of medical necessity. And the Act imposes a three-year moratorium on new facilities -- a limited three-year moratorium on new facilities -- and requires the Secretary to conduct a study on the use of LTCH facility and inpatient criteria to determine medical necessity and appropriateness of admission and continued stay.

So on to payment adequacy. I'll just summarize the findings Craig and I presented last month.

First, supply appears to have stabilized. After a

long period of rapid growth, the increase in the number of LTCHs participating in the program has leveled off. Preliminary data suggest a fairly stable situation for 2007, as well. Beneficiary use of services suggest that access to care was maintained during the period. We have no direct indicators of beneficiaries' access to services, but assessment of access is difficult regardless because we have no criteria for LTCH patients.

Turning to quality, we looked at several measures that can be calculated from routinely collected administrative data. Last month we told you that the evidence on quality was mostly positive. New data have changed our findings a bit and now show quality to be a bit more mixed. I can go into that more later if anyone has questions.

Access to capital going forward is difficult to determine. Until recently, the industry's access to capital has been very good. We saw fairly dramatic growth in the number of facilities, and private equity firms were investing quite heavily in the industry.

Some financial analysts argue that in the current environment, even private equity firms might not have access

to capital and that some of the smaller chains are already highly leveraged, which makes things certain going forward.

On the other hand, some financial analysts we spoke with believe that dire predictions about Medicare payment reductions have not come to pass, that business should stabilize over the next year, and certainly that payment policy changes under the Medicare, Medicaid, and SCHIP Extension Act will improve the financial picture.

Regarding payments and costs, in spite of the changes wrought by the new law, we are projecting that payment policies implemented in 2007 and 2008 will reduce aggregate payments. Historically, cost growth in this industry has closely track growth in payments. It remains to be seen whether the industry will constrain cost growth in response to these recent payment reductions.

Margins for LTCHs rose rapidly after the implementation of the PPS, rising from a bit below zero under the cost-based TEFRA system to a peak of 12 percent in 2005. And in 2060, they remain very high at 9.4 percent. As you can see, there's a pretty wide spread in the margins, with a quarter of hospitals having margins 3.5 percent or less and another quarter having margins of 19 percent or

more.

For purposes of projecting the 2008 margins with 2009 policy, we modeled a number of the policy changes that have taken place since 2006. Since we last met, we've also had to make some adjustments to our model based on recent changes in law. We've included the payment increasing effects of updates and coding improvements due to implementation of the MS-LTC-DRGs. We've also included the payment decreasing effects of DRG weight changes that were made in 2007, as well as changes CMS made to the short stay outlier policy in 2007, changes that were not affected by the new law.

Since the enactment of the new law, we've removed the effects resulting from the very short outlier policy, which was revoked. And we've also included the implementation of the 25 percent rule to the 50 percent level for hospitals within hospitals and satellites. Last time we had it all the way phased into the 25 percent rule.

And of course, we're not including the phase-in for the 25 percent rule for freestanding facilities any longer. As I said, we do anticipate a net decrease in payments and thus we're projecting a substantial decline in

margins, assuming provider costs go up at market basket rates of increase. If the industry responds to these payment changes by restraining their costs, margins could be somewhat higher than we're projecting. We project a margin of between minus 1.4 percent and 0.4 percent for 2008 and the difference in these projections reflects different assumptions about the impact of the 25 percent rule.

The lower margin assumes hospitals within hospitals and satellites will make no changes in the patients they treat in response to moving to the 50 percent threshold in 2007 and beyond. The higher number assumes hospitals within hospitals will adjust their admissions so they stay under the limits and thus will not have payments reduced.

So in summary, assessing the current payment adequacy in this sector is a little difficult. Recent policy changes have reduced payments. Growth in facilities and cases has slowed, which calls into question the adequacy of payment and access to care. However, it's difficult to determine when the use of services is appropriate and necessary. Frequently LTCHs enter the program in market areas where LTCHs already exist, raising questions about

whether there are sufficient numbers of very sick patients to support the number of LTCHs in some communities. So seen in this light, recent slowing in facilities, cases, and Medicare spending may be desirable.

The payment changes under the Medicare, Medicaid and SCHIP Extension Act do improve the financial outlook. Nevertheless, our estimated Medicare margins suggest that LTCHs may not be able to accommodate the cost of caring for Medicare beneficiaries in 2009 without an increase in the base payment rate.

So that brings us to our draft recommendation, which reads as follows: the Secretary should update payment rates for long-term care hospitals from rate year 2009 by the projected rate of increase in the rehabilitation, psychiatric, and long-term care hospital market basket index less the Commission's expectation for productivity growth.

Under current market basket assumptions this recommendation would update the LTCH payment rates by 1.6 percent. This recommendation would decrease Federal program spending by less than $1 billion over five years. And we don't expect it would adversely affect Medicare beneficiaries' access to care or providers ability to

furnish care.

So now I'll turn it over to you.

MR. HACKBARTH: Thank you, Dana.

Let me just highlight one thing. I think this is, other than hospitals, the only provider group for which we project negative margins. I think that's right. Here the recommendation is market basket minus productivity, whereas for hospitals we did full market basket concurrent with pay for performance. I just wanted to highlight that and why I think differently about the two issues.

In the case of inpatient hospitals, the margins are somewhat more negative, number one. And they have been persistently negative over some period of time.

Here we have a different history. Here, until recently, the history was not just positive margins but substantially positive margins. And so I think that warrants thinking about it a little bit differently.

Let me just stop there, having highlighted that. Nancy-Ann did you have a comment?

MS. DePARLE: Thanks for that explanation because I do think it's important. We've discussed before and today our desire to be consistent as we look at the different

sectors to the extent that we can. So I think that's helpful.

I just wanted to ask about the quality data that you mentioned, the more recent data that appears to show a more mixed picture with respect to quality of care in LTCHs.

And also, I'm a little bit surprised, I think in response to Mitra -- or no, her question was about CON. In response to someone, you provided some information about commercial insurers and their proclivity to use LTCHs. That's a little bit at variance with what I've heard from some of the LTCH providers about their increases in utilization by managed care organizations. It may not be inconsistent with what you found but I'm kind of surprised by it.

So you looked at national managed care contracts? Or how did you determine that?

MS. KELLEY: I spoke with representatives from a couple of the major plans and just asked them specifically. I spoke with a medical director, a regional medical director, and some utilization review people.

MS. DePARLE: Did you ask them whether or not their utilization of LTCHs has increased overall?

MR. LISK: I think they said that it had increased. One of the companies have both a private fee-for-service plan and they have no real control over use of LTCHs in that plan, whereas in the Medicare pure HMO where they have a little bit more control over that and they use them, where they have to get permission.

I can't remember whether they said 40 or 60 percent of the cases they end up approving for use. And then the others they tell them to go back. A lot of times they don't ask again. That was one of the things that happened.

But again, we're talking about interviews with a couple of people on this.

MS. DePARLE: I'm talking about discussions with one. So were you only looking at Medicare patients or did you ask them about -- I realize a large percentage --

MS. KELLEY: We were primarily talking about Medicare.

MS. DePARLE: It could also be the case that for other patients they were using them more.

MS. KELLEY: They certainly reported that the requests for transfers to LTCHs had increased markedly in

recent years, particularly in certain regions of the country, Texas, the Southwest and Southeast was mentioned.

So there did seem to be a correlation to where we've seen growth in the number of facilities, the requests for transfer to those facilities seems to be increasing along with that growth.

MS. DePARLE: I interrupted my first question to you, which was could you talk a little bit more about the quality measures?

MS. KELLEY: The quality measure was a refinement we did to the analysis. We look at four patient safety indicators that are used in acute care hospitals but that seem to be appropriate for use in LTCHs. They are decubitus ulcers, infection due to medical care, pulmonary embolisms and deep vein thromboses, and postoperative sepsis.

When we initially did our initial analysis, we removed patients who had any diagnosis in the acute care hospital that would trigger the PSI. So that we're not penalizing the LTCH for accepting a patient that already has this condition. In refining the analysis, we also decided to remove patients who were admitted directly to the LTCH and didn't have an acute care stay because we couldn't

control for their condition when they came in the door. When we did that, our numbers changed very slightly but one of our number slipped from a slight improvement in quality to a slight decline in quality. And that just made the picture a little bit more mixed.

MR. EBELER: I was going to offer a productivity offset on the hospital side to solve your equivalence problem but I think we already voted on that.

This assumption that the institution's behavior won't change, their cost growth won't change, and they will then move into this negative margin category is interesting. I guess there's no other assumption we can make. But realistically, I wouldn't assume that would happen. They're going to respond.

I don't know this business that well. What is the likely response? How do they not make those negative margins happen? Because they won't let those happen.

MS. KELLEY: I can only speak about the historical trends. Under the TEFRA cost-based system, cost growth in this industry is very low, sometimes negative. Since the implementation of PPS, payments have increased dramatically and cost growth has tracked very nicely right along with the

payment growth.

So as I said previously, cost growth has tracked very well with payment growth historically in this industry and I would be somewhat surprised to see that change at this point.

MR. EBELER: If that's the assumption, then the margins will stay roughly where they are because payment growth has stopped.

MS. KELLEY: Margins have declined in the past couple of years from the high of 12 percent in 2005.

MR. EBELER: Thank you.

DR. MILLER: I'm going to pick this up because I think this is a good question. And the three of this us have been through this many times. And actually I appreciate the fact that you guys didn't just leave the table when this question came up again because we've gone through these estimates time and time again. I would say a couple of things.

If we had come in here and said you know, they're going to eliminate all of this cost immediately, people would have said wait a minute, that's a pretty aggressive assumption. So we're trying to strike some balance there.

And it came through in the presentation but I just want to hit it again, we're getting very mixed signals out there. You talk to the capital markets, you look at the assumptions. To the extent that we can quantify these assumptions, this is our best shot at the margin.

But if they respond on cost, this will be higher. If that half of the capital markets who says you know, there's a lot of revenue that these people have, and they're very good at selection and also cost control, they're coming back, these margins are going to be wrong.

This is an area that we spent a lot of time back and forth trying to get our head around this. This is our best shot based on the quantitative and some sense that we didn't want to come here and be way over on one side of yes, they're going to recover. We're trying to be a little conservative here.

DR. REISCHAUER: I want to offer a technical corrections amendment here, both in the dialysis -- which I apologize for being out of the room for -- and the draft recommendation here. It has to do with how we explain what, in fact, we're doing.

In the dialysis one it says market basket index

less the adjustment for productivity growth for the calendar year 2009. That makes it sound like we're estimating what productivity growth is going to be in 2009, which we aren't. What we're doing is we're taking trend productivity over the past 10 years as estimated by BEA.

And then this one says market basket less the Commission's expectations for productivity growth. That also makes it sound like we're looking forward.

I suggest we change for both of those into market basket index less the Commission's adjustment for productivity growth, period. We've explained elsewhere what that adjustment is, which is 10-year moving average of total factor productivity. Just so we don't create confusion here.

MR. HACKBARTH: Is that clear to everybody?

MS. THOMAS: Can you say it one more time so I get it?

DR. REISCHAUER: [off microphone] Market basket index less the Commission's adjust for productivity growth.

MR. HACKBARTH: Other questions and comments before we move to a vote?

DR. CROSSON: I had just one, and maybe I'm

catching the economics virus, too -- economist virus, excuse me.

I just wanted to understand the spending implication as an expected decrease. Is that because what was built into the budget was market basket? Or did I miss something about the 2009, I mean about the recent legislation and its impact on 2009?

DR. MILLER: I think your situation is worse than you think. You're starting to get a budget virus here because this is a baseline issue.

MS. KELLEY: There's no -- what am I trying to say? There's no stipulation in law for an update for LTCHs. CMS has stated that they're going to stick to the policy of a market basket increase. They've applied different adjustment in the last several years that have prevented a full market basket increase from being implemented. Adjustments for cording improvements being one of the factors that's been used.

So our spending implication is based on the assumption that there would be a full market basket increase, but that is not in law.

DR. MILLER: Which is also what the CBO baseline

is assuming, which is what we use for all of these to figure out what the budget effects would be.

MS. DePARLE: But we won't really know that until the President's budget comes out; right? That could change, what the Administration is proposing.

MR. HACKBARTH: Any others? Okay, let's vote.

All opposed to the draft recommendation, as amended by Bob? All in favor? Abstentions?

And just for the record, on amending the ESRD recommendation so that it confirms, and we're clear, all in favor of doing that?

Okay, thank you. Well done.

We're going to shift our focus here for our last session, having completed our update work for another year. The last year two sessions, the first on bundled payment and the second on primary care, go back to our longer term agenda on how to reshape the incentives that we provide for the delivery of care.

And among the themes that we talked about at our retreat last summer and in our fall discussions of this was let's talk about ways that we can break out of the siloed payment systems for different providers by type. Let's look

at ways that we can encourage -- as Arnie has put it often -- think about longitudinal efficiency, how we improve care for patients over longer periods of time, not just very discrete encounters.

Third, let's think about payment approaches that can provide a solid foundation for rewarding a more robust version of pay for performance in the future that emphasizes efficiency and quality.

And finally, let's consider proposals that will help shore up, indeed improve, our primary care system.

So those are a few of the themes that we talked about before. And in these last two discussions today we're going to dig into those issues a bit further.

MS. MUTTI: As Glenn mentioned, this past fall we discussed the concept of bundling payment for Part A and Part B services surrounding a hospital admission. We talked about the related issues involved in that effort.

At this juncture, we'd like to take a moment and almost step back and see if there's a general consensus among you on some of the general points around bundling. We feel that this kind of conversation at this point would help us begin to think how we might shape a June chapter.

So today, I will present some themes where we think we've heard agreement from you, or more or less agreement. And then I'll outline a phased-in approach, a type of glide path, that would ultimately move Medicare to making a unbundled payment for care around a hospitalization.

Our hope here is that by having a specific policy approach laid out that it will help you assess what the implementation issues are and where you really are on this issue, exactly how it could be implemented.

A key fundamental theme to our conversation on bundling is a recognition that fee-for-service payment does not reward efficiency over an episode of care. By paying providers piecemeal, Medicare gives providers no financial incentive to work cooperatively to manage patients' care over time. As a result, patient care can suffer and Medicare and beneficiaries may spend more than is really needed.

This statement is grounded in the research that shows geographic areas that spend more on health care do not have better quality of care over areas that spend less.

Bundling payment can improve incentives for

efficiency over an episode of care. Just to briefly step back for a moment, bundled payment is where Medicare pays a lump sum to a provider entity. This lump sum is then designed to cover the costs for efficient providers for providing care during a designated episode or window of time.

So why does bundling improve incentives? There's two dynamics at play here that we've just talked about. First, when the bundle includes care provided by just one provider, the provider has a clear incentive to monitor or restrain the volume of service use under the bundle. More services are not rewarded with higher payment.

When bundling payment across different providers -- something Medicare has not done before outside of the MA program -- an added dynamic is in motion. Providers have an interest in collaborating with one another, with other partners, to improve their collective performance. This collaboration might mean better communication among providers, less redundancy in care, more attention to the mix of prescription drugs that a patient is taking, and just general improvement in the coordination.

Another important point that I think you all have

expressed is that we don't get value with low resource alone. We need to encourage and reward quality, as well. Accordingly, concurrent accountability for quality is essential. This is particularly important because while bundling changes incentives to reduce overuse, which is part of a quality problem, it also creates some incentives for stinting or underuse.

So here we are envisioning that providers are accountable for quality through a P4P program, concurrently with bundling.

Hospitalization episodes may be a good place to start in expanding application of bundling traditional Medicare. This is for at least a couple of reasons. First, hospitalization is a clear, cogent episode of care, making it very reasonable to hold multiple providers accountable.

Second, there is value in engaging hospitals in identifying cost savings rather than focusing on physicians and their power of the pen alone. Hospital's managerial and financial resources can be an asset in enabling delivery system reforms as can the economies of scale they command.

They need a financial incentive, however -- a business case if you will -- to use these resources to

better manage physician visits during the stay and patients' care after discharge.

We've also heard from you that there is value in first focusing on selected conditions. To gain experience, achieve early success, and limit unintended consequences, any bundling policy could first apply to a select number of conditions. They could be selected based on the frequency of the condition, the relative high cost of the condition, availability of quality measures, and the ability to improve performance, among other factors. We do recognize the potential flip side here, I think one of you mentioned it a couple meetings back, that the investment required to implement bundling may be significant enough that considerable economies of scale would be achieved by applying it to a greater number of conditions, perhaps all conditions. --

So that's just something to bear in mind as we go forward with this.

Another theme that we heard from you is that there is value in defining episodes that extend beyond the stay, but that you recognize the need to start slowing. First, why is beyond the stay important? This is where the

variation is in spending, and we showed you that in some of the slides this past fall. These transitions in care are occurring during this time. So by definition there are transitions during this time and some of them are not particularly well handled. We've talked about the frequency of readmissions in a two-week through 30-day window and the costliness of that for Medicare amounting to something like $15 billion in the 30-day window.

But as you've said, a slow start is needed. Why is that? Bundling payment, especially for an episode that extends across sites, require significant changes for providers and design challenges for CMS. These include providers having signed legal contracts among themselves, refining risk adjustment to better account for reasonable differences in post-acute care costs, providers developing systems to not only better manage the patient care but then to figure out ways to pay one another.

We've also alluded to the fact that we might need some policies to control any possibilities of increasing the number of bundles, the number of admissions that might occur.

For bundling to achieve its potential, we will

likely need to ease current regulatory restrictions like that on shared accountability or gain sharing. We've talked about this before. Those kinds of restrictions might prohibit providers from constructively collaborating with one another to improve efficiency.

At the same time, we will need to consider new regulatory approaches to discourage possible growth in admissions, as I just mentioned. Growth in the number of admissions is a concern because bundling aligns hospital and physicians incentives. While growth in admissions was also a concern with the creation of DRGs, we feel that this policy is different. DRGs in and of themselves did not align hospitals and physicians. In a sense, the potential effect of bundling on volume is more analogous to the development of physician-owned specialty hospitals. And here MedPAC and others have found an increase in volume.

The broad point is that if financially physicians are better off admitting patients -- as may be the case under newly negotiated physician rates under bundled payment -- then we have inadvertently created a business case to admit patients who could have been treated just as effectively on an outpatient basis. We need to be mindful

of this possibility and consider ways to balance incentives.

Here we get a little bit more concrete and offer a policy glide path that takes into account some of the themes I just mentioned. On this slide, I will briefly list the four steps and then say a bit more on two, three and four in the following slides. An overarching consideration to keep in mind is that we envision that this glide path would start by applying to a few selected conditions and expand that number over time, perhaps over the course of the policy phase-in. But we aren't any more specific than that at this point.

The first step is to provide information to hospitals and physicians about the resource use during the stay, as well as some post-discharge period, perhaps something like 15 days after discharge, so that they can know how their performance compares to others and possibly identify ways they can improve. Information would be provided for the two time frames in anticipation of ultimately holding them accountable for the longer one.

The next step is virtual bundling for the stay only. That is, Medicare would pay providers separately but adjust payment to each based on the relative average

Medicare spending for care during the stay. I'll come back to this in a moment.

The third step is then to implement mandatory bundling, again for the stay only, so that Medicare would only pay providers for inpatient care for certain conditions if they were able to accept a bundled payment. The bundled payment would be for all hospital and physician services during the hospitalization.

The fourth step here, Medicare would increase the bundled payment to cover the care delivered during the stay plus some time after.

So now, having given you the overview of the phase-in, let me spend a little bit more time on some of these steps. The second step would be to apply a virtual bundling policy for care delivered during the stay -- just during the stay, as I mentioned, not the post-discharge period.

As you might recall, virtual bundling is where Medicare would continue to pay separate amounts to each provider but would penalize providers -- reduce payment amounts to those provider groups -- whose risk-adjusted spending exceeded benchmark or expected resource use. There

could also be a reward for high-performing provider groups.

Virtual bundling is an appealing incremental step to truly bundling payment because it can make providers conscious of their role in creating efficient episodes and aligns provider incentives without requiring providers to fully establish an administrative and legal construct to jointly accept a bundled payment and then share it.

There are a variety of implementation issues to consider here and that we can discuss in the chapter. They include how large the penalty should be, whether it should grow over time. Should there be a reward or a carrot for good performers? What are the budgetary effects of implementing that aspect of the design? What should the benchmark or expected spending levels be? Is it the 50th percentile, the 75th, other options?

I will just step back for a moment after I've talked about steps one and two, is that you might notice that this glide path, those first two steps, sound a lot like our vision under physician resource use measurement. That is, we first share information with providers with their practice styles and then ultimately adjust payment for those who use excessive resources.

We think that notionally the two approaches can coexistence and indeed can be mutually reinforcing. But if the two were pursued simultaneously, thought would need to be given to simplifying implementation.

The third step is mandatory bundling for the stay only. This means that in order to get paid by Medicare for select conditions, hospitals and physicians will have to be able to accept a bundled payment. Our thinking here is that the first two steps should have given providers sufficient time to reengineer and align incentives to allow them to accept the bundled payment. Once under the bundle, the providers would then have the incentive to work together to reduce costs. They may reduce the unit of service like the number of physician visits, as well as the cost of services, such as supplies, length of stay, ICU time, that kind of thing.

The fourth step would be mandatory bundling for the stay plus some post-discharge period. This step requires that the entity accepting the bundled payment be responsible for paying services delivered subsequent to discharge. This includes SNF care, home health services, and readmissions within some window. Again, we throw out

the idea of 15 days but that's kind of open here.

While the entity is managing a degree of insurance risk here, it is very likely that the hospitals and physicians involved in the hospitalization do have the ability to directly influence the efficiency of care within this time frame.

Implementation of this step would be contingent on the availability of acceptable risk adjustment.

Over the next couple of slides, I want to point out what this policy doesn't do. First, it does not allow providers to voluntarily opt to receive a bundled payment during steps one and two, that is prior to it becoming mandatory in step three. This may seem frustrating because we know that some systems are ready to accept that bundled payment.

The logic for not allowing voluntary bundling has to do with the challenge of setting the right payment rate. If we set it at the national average amount, which was done under DRGS, and only the low-cost systems -- those that have the greatest ability to gain under this -- if they are the only ones that opt for the bundle, Medicare loses money. A way around this problem might be to set the payment rate

differently, as a discount off each hospital's current combined payment amount, as was done in the heart bypass demonstration. But because each hospital has its own base rate -- it's the combination of the hospital and physician payments per condition -- and that would have to be calculated by CMS and subject to appeal, this could be quite a laborious administrative task and seemingly prohibitive if potentially every hospital pursues that option.

Second, this policy glide path requires no accountability for readmissions until step four. Depending on the phase-in, this could be a fairly long time. It is possible to pair a readmissions policy with bundling, and if you're interested in this we can come back you and discuss how this might work in more detail.

So with that, let me leave you with a few questions. Are there additional main themes that we should highlight? What do you think of the glide path? And in that context, we have a couple of specific questions. How specific should we be in the defining post-acute period? I've thrown around the example of 15 days. Is that right? Is there a better way? Are you okay with a no voluntary bundling approach here? Would you like us to explore a more

aggressive readmission policy?

Another question for you is whether or not to make a recommendation. Given the range of design issues still left to analyze, you may not want to recommend the full glide path. One possibility though is to recommend step one only, the disseminating information step, and wait for more details to coalesce and further discussion on the other steps. Or perhaps there's a place for a recommendation somewhere in between those two.

I'd also like to note that this policy option implicates some large strategic and philosophical issues, and you may want to talk about those, also. For example, particularly if bundling were enacted in isolation and not in tandem with some other policy options we've talked about -- physician resource use measurement or that kind of thing -- it would be giving hospitals a very strong role in catalyzing delivery system reform. That might give you something to think about.

Also, this policy would likely create powerful hospital physician entities positioned to have influence in setting future Medicare payment rates and in negotiations with private insurers, again something to think about.

I'll stop there.

MR. HACKBARTH: Well done, Anne.

Let me pick up with the virtual bundling piece. As Anne indicated, one of the reasons for including virtual bundling had to do with the problems created if it's an optional system and the potential increasing effect of an optional system.

The other theme that I remember from the fall originated with Arnie, which is not everybody is going to want to enter into formal organizational relationships with corporate structures and all of that. And virtual bundling might be a way to allow people to legally continue to be disaggregated and not part of the big organizations but still create incentives for them to behave the way we want them to behave. So I think there was a two-pronged rationale for thinking about virtual bundling.

One of the implications of the second point of view might be that you continue it longer term and not just as only a transitional device.

So I just wanted to highlight that as something for discussion.

MR. BERTKO: The first thing is to compliment Anne

and Craig on a very thoughtful glide path. Then of course, once you get to this the question becomes down into some of the details.

So I'm with you on step one and step two. And then, since I live in a little one hospital town, step three becomes a question.

Arnie and I and Jay, people who have had experience in the West where we had all kinds of PHOs springing up like mushrooms in the 1980s and 1990s, saw them blow up. And so in your glide path I noticed for step three you have what appears to be a very big stick. So if somebody checks in to the hospital in my town and nothing is there, the hospital doesn't get paid. Which would seem to create an access problem because they would have to go 150 miles down the highway to some hospital in Phoenix that, in fact, accept this.

You're nodding, so I interpreted that correctly then?

So then that brings up the next question that I think Glenn might have been alluding to is do you have some kind of bifurcated system in the early days because I'm absolutely certain that hospitals and physicians will move

into step three at very different speeds. Is there a way that that's allowable without creating selection? And then, after you've answered that one I have a follow up but different question.

MS. MUTTI: Not that I have an answer for it, but just to be clear in the presentation, when we said no voluntary bundling, that was envisioning -- we have talked about this inclination like wouldn't it be nice to get those who are ready to go ahead with it? And we just have not been able to figure out a way -- and we'd certainly welcome suggestions of how to do it in a responsible budget way that was also administratively feasible, because you could imagine a system where you kept the virtual bundling for those that did not opt to take the bundled payment. And there would be some penalty if they were high cost.

But as we play it out, we just find so many different uncertainties, unintended consequences of gaming the system. You have physicians that admit to two different hospitals, one that takes the bundle, one that's under virtual. It gets complicated.

MR. BERTKO: Could I offer and see whether you've thought about this. My state has very, very large

geographic counties and whether it's county or MSA, there wouldn't be a choice but it could click on by county. So Maricopa County, the moment one hospital entered, all would have to be in. whereas Coconino County might be slower and so it might lag in turning on before Maricopa County did. I don't know if that's an acceptable thought or not.

DR. MILLER: John, could I just ask one thing about that? How did that solve the initial problem that you said? So if that one hospital doesn't do it, is somebody still driving down the road?

MR. BERTKO: Not likely. Not at 150 mile difference for these big ticket items, the selected procedures.

DR. MILLER: Then why was it a problem in the first place?

MR. BERTKO: If you live in Maricopa County, you would have the hospital that was efficient in cardiac care turn the bundle on, and the one that was inefficient stay in the fee-for-service if that was advantageous to them, or vice versa, where there were two or three competing hospitals in the same catchment area.

DR. MILLER: This is not disagreement. I didn't

follow set up and then the solution.

MR. BERTKO: In Arizona, outside of Phoenix and Tucson, there are basically single hospital towns. And the distances are large, 50 to 100 miles. So you don't really have much choice except for tertiary procedures, and then they helicopter you down. I'm thinking there are other parts, at least of the West, that look a lot like that.

In this spirit of discussion here.

DR. MILLER: [off microphone] It's really not disagreement. I caught the problem and then I caught what I thought the solution was. And I couldn't [inaudible].

MR. BERTKO: In other places like in California there are frequently fairly intense competition in most of the urban areas. You pick the nine county greater San Francisco Bay Area, the moment one hospital clicks on you turn on the whole nine counties because there is, in fact, competition even with traffic flow and such.

I've kind of exhausted my thoughts on that one.

Now I'd like to ask the more difficult question than that, which is interesting. Glenn, you alluded to this. I think of our episode grouper work on Minneapolis versus Miami, if I'm thinking of it correctly. We had many

more episodes down in Miami than in Minneapolis, and had cheaper rates. Under something like this, without an appropriate geographic adjustment, the people in Miami could have a huge benefit under this kind of payment system.

Would you think of it geographically to adjust for this? Or is there some other way to constrain utilization that you thought about?

MR. HACKBARTH: The benefit, John, would be more lower-cost episodes and Miami would allow them. If you used a national average rate they could gain and Minneapolis lose.

MR. BERTKO: Yes.

DR. REISCHAUER: I thought that started with a diagnosis of congestive heart failure, not entrance to a hospital. The big difference was fewer people in Miami ended up going into the hospital. The ones that went in -- and they were less severe, even the ones that went in, than the people that were in Minneapolis.

MR. BERTKO: I agree you're correct on that, but I was taking it to the next logical conclusion. If that happened you could game the system to get more admissions in Miami because you have people stacked up on these.

MR. HACKBARTH: This is an empirical question and we'd have to look at the data. But it goes to how set the rate. And do you use national averages? Do you use local averages? The different options that you can pursue there with this as one of a number of issues in mind.

MS. MUTTI: One other thing that we've begun to think about with respect to that is looking at admission rates. Maybe I alluded a little bit to this. We have concern with this policy that you might see a bump in admission rates. But whether you see that bump up or not, it would be nice if we could start measuring and comparing hospital specific admission rates. And we're hoping to do some research.

The trick here, I think you pointed this out at the last meeting, is developing a denominator of beneficiaries for each hospital. We're going to work with some of the Dartmouth algorithms in assigning and explore what possibilities there might be on that.

MR. HACKBARTH: Capitation is way simpler than this.

[Laughter.]

MR. HACKBARTH: I just thought I'd note that.

DR. KANE: I am on the same mindset as John, actually, around some sort of geographic rather than provider specific beginning.

Even if it is at the geographic level you're worrying about population health measures that help set the level of payment and that as the geographic health measures get better the level of payment gets better. I don't think you should do this unless you can do something about the population's health at the county or whatever the natural market area is that helps you adjusted for the admission rate.

And also, I remember the guy fro -- was it Virginia Mason who came in and said they did some huge outreach in flu immunizations and he said it killed them to go out and try to do that because then they didn't have a huge flu season to pay the hospital with all the sick people. And there should be a reward for that.

I think I would be hesitant to do that without some kind of a geographic -- even if it's only part of the payment design. I agree, capitation is easier. But we don't know what happens when we capitate. We never find out after that where the resources went. Whereas under the fee-

for-service program at least we'll have some idea of where the resources are going and be able to measure quality more directly.

Anyway, I do think something about the geographic -- the health of the population in a geographic area has to be part of the payment system.

The other part about the incentive, whether it should be a withhold versus one year to the next. I thought we've already heard that the closer the payment is to the behavior the better impact it is. So I'm more for the quarterly settlement idea than two years later you get the impact of good behavior. Some organizations won't have the financial wherewithal to get to that two years later. I think it's better to have that payment reward connected as close as possible to the time the behavior happens.

DR. MILLER: Just on that point, a mandatory payment based on the bundle is about as close as you can get it.

DR. KANE: And it goes up and down by quarterly adjustments by what's happening --

DR. MILLER: I'm saying steps three and four, which you need to sort out, is here's your payment. Now

manage to it.

DR. KANE: It's pretty immediate.

DR. MILLER: Pretty immediate.

DR. WOLTER: I wanted just to highlight a few things in my thinking. First of all, I really do think this was very thoughtfully laid out and a measured approach you took to implementation is probably necessary if we're going to take it somewhere beyond just an experiment or a demo. So I really like that. I like the theme of continuing the virtual bundling along the whole pathway. And I certainly would agree with Glenn. Who knows, maybe that stays in place in some way, depending on how these relationships evolve.

I wanted to highlight the importance of the regulatory restrictions that would have to be dealt with to get into this. That's a very large deal and we'll need to be very thoughtful and maybe even emphatic about the need to get those things addressed because, Anne, one of the concerns you've voiced that these relationships could lead to incentives for increased admissions at all that, in my view sometimes get in the way of our ability to look at new innovative organizational models of care.

And if the issue that we've identified in Fisher's work is that in any case most admissions to a hospital come, largely speaking, from a similar group of doctors. And on the physician's side most of the patients they admit tend to go to the same hospital, which is at least part of his summary.

We're already in that boat and I can tell you hospitals are already doing everything they can to incent volume in one way or the other, especially where the DRGs are profitable.

And so if we could create a tighter relationship between the physicians who admit high-volume, high-cost patients to hospitals, and then put in place the appropriate accountability for how that care is delivered both cost and quality-wise -- and I would agree, continue look at geographic utilization variation -- we then have an accountable care organization we can start to give information to.

I was at a meeting up at Dartmouth and Elliott and Jack presented to those of us who were in attendance our comparisons in the ICU days in the last two years of life. It was fascinating and very revealing. I mentioned that one

because we looked very good.

[Laughter.]

DR. WOLTER: But we didn't look so good on neurologic procedures, actually. So it creates all sorts of opportunities if we can find a way to do this.

The P4P part, looking at these geographic variations and then having that information in a way that we can incent people to narrow those variations is really the opportunity we have here.

I really would like us to look at readmission rates. What time frame that is I don't know. I wasn't crazy about the financial framework report we put on that in the last look we had at it, but I think we can play with that some more. And I think readmission rates are a huge opportunity, as we've said.

And then I want to comment on the issue of hospital control and territorialism which, of course, physicians really do worry about. I don't think this only has to happen with bundled payment going to the hospital. One could imagine new organizational forms springing up that respond to this that include physicians in governance in ways that we need to have happen anyway.

I keep referring to the Middlesex Group that's in the group practice demo. They're actually taking responsibility for an entire year of payment for all Part A and Part B payment, in a way, because of the way the demo is set up. And they are not employed by the hospital, most of them. It's a virtual kind of a group that's come together.

So I think there's ways through that issue and it's a very important issue so that physicians feel they are part of how these things are designed and implemented and lead.

And then just lastly I would say, as you all know, this is the type of transformational change and innovation we have got to find our way to try if we're going have a chance to deal with the problems that we're dealing with.

MS. HANSEN: I just wanted -- hearing these structures, I also want to say that capitation not only should be easier, having been in it, it is a lot easier doing it that way. But just building on Nick's last point about changing the whole culture of practice, that again the variations that you're going to be looking at with the Dartmouth folks is great.

The whole area of readmissions is one that I think

is one that I would also underscore and refer back to perhaps other types of entities, whether they're the ones like Middlesex Physician Group, or work that is already being done right now that I think was reported even publicly in the Wall Street Journal with the health plan side of it, with Kaiser I believe and Aetna, with the work from the University of Pennsylvania and Mary Naylor with the transitions work that she does with Eric Coleman.

And I wonder if we could have some presentation at some point about that, because we look at it in terms of just the results of better care for people and the rehospitalization rate is really one of the things that comes out strong, at least in some of the initial NIH studies that have been done.

If we life that a little bit more and remember that that's what we're driving for, not so much the structures but the impact to the beneficiaries not having to use these services. And then couple that with Nancy's point about the population base itself.

So I just wonder if we could life that component to look at it from the endpoint of the quality of the care to the beneficiaries that gets increased because of, for

example, unnecessary readmissions in certain conditions.

MR. EBELER: I can be quick here because a lot of the points have been made better than I would make them.

Thank you for doing this. I think this issue of what is the entity that can collect the money, and Nick's point that in our heads of sort of sounds like the hospital distributing the money. But we really should be open to very different arrangements in that world. Because what we're challenging the community to do here is change. We want changes. I think that's really critical.

There is an issue I suspect substantively and politically of hospital size that may be what John was getting at where neither the volume of procedures nor the structure of the institution merits going much beyond virtual bundling. It seems to me it would be worth looking at that, whether it's worth taking on that fight or just simply leaving that.

I don't know how to deal with it but there's a size here that is just, I suspect, hard for them to do and not worth us pushing it because the issue in those communities is are there resources to do something, not how do you reorganize the resources to do it. It just seems

worth looking at.

A question on the time frame. Should we look at these steps pragmatically as years? Or is each step two years? Do you have a sense of how long it takes to get from step one to step four? Days?

DR. REISCHAUER: Decades.

MS. MUTTI: In my thinking, I was playing off what I had heard you all say. I think at one point you said this could be 10 years. Somebody said I don't know about that.

I'm trying to reflect what you're saying. We do not have an independent vision for how long this takes. I think there was some recognition that this is complicated. So if you'd like to offer up a time frame, that's fine.

[Laughter.]

MR. EBELER: I had it written down by month. I just don't have a feel for how long this takes.

DR. REISCHAUER: Anne and Craig, I think this is terrific work and it's really the kind of thing we should do, which is think quite clearly how one would really go about doing this. You've solidified my pre-bias that it's impossible, quite frankly.

[Laughter.]

DR. REISCHAUER: What we're trying to do is sneak up in a politically acceptable way on the fact that to get what we want a strong accountable care organization or a group or staff model HMO is the only answer. But we can't say that, so we're going to pussyfoot around the edge and try and sneak up on it.

And I'm sitting here thinking about virtual bundling. And I'm thinking well, we could pay the people separately based on the average episode spending. So let's take one thing, whatever it is, and everybody goes into the hospital and gets the same thing done.

And then there's four doctors. And some people have an episode and see one, some see two, some see three, some see four. There's three post-acute care things. Some go to one, some go to none, on everything. So how do we figure out what the average is for all of these episodes?

And then the payment, you might be making the payment for some doctor who only was involved in episodes where there was one doctor visit and so "efficient" things. And he's getting smashed because half of the other cases saw four doctors and he has no idea why he's getting from Medicare half of what he used to get.

What I'm afraid of is by going down some of these roads you're going to create such a backlash that it's going to be equivalent to managed care during the early 1990s, everybody, great idea, great idea. And then people say oh, you're stinting on care because we didn't measure quality, et cetera, et cetera. And we turn back the clock on something that maybe was an okay idea.

I think you go into this with teeth or not at all. And it's conceivable that in certain areas it's just inappropriate because of the scale, because of the lack of competition it just can't be done. And this kind of stuff can only be done in large metropolitan areas with five or more hospitals.

Then we run into the whole problem of but this is Medicare and we have to offer everybody -- whether they live in Bering Point, Alaska or New York City the same thing.

I await your next chapter.

MR. HACKBARTH: And I await the punch line here.

[Laughter.]

DR. REISCHAUER: It's impossible wasn't good enough for you? What do you want, the movie?

[Laughter.]

MR. HACKBARTH: So, Mr. CBO Director, how is it you think we slow the rise of Medicare costs? You want to just squeeze the updates?

DR. REISCHAUER: No, I don't. This is a longer discussion and I'm not sure I want to provide my secret solution --

[Laughter.]

DR. REISCHAUER: -- before the patent has been approved. But quite frankly, I think you create organizations such as I have said could work, and you provide payment through the Medicare system equal to what those folks need to provide high quality. And if other people want to be in some other system, that's just fine but the differential cost, they're going to have to bear.

MR. HACKBARTH: As you can imagine, Bob and I have talked some about this.

DR. REISCHAUER: He's pretending he doesn't agree with me.

MR. HACKBARTH: I think if I could snap my fingers and make something happen, I'd enroll everybody in Kaiser Permanente sort of organizations. Ain't going to happen.

So one way to think of all of this, in spite of

all of its complexity, is that what you're trying to do is use payment to drive organization and start creating the building blocks that are part of the path to a more Kaiser Permanente sort of organizations.

We tend, in the political world, to think our payment systems always have to adapt it to the existing organization. And then we bemoan how bad the organization is and we get caught in this vicious, negative cycle. We're going to have a different mindset, which is to use payment to force changes in organization.

The problem there, as you well point out, is the political barriers. So we get into thinking about transitions and virtuals and whatnot.

I'm searching for a path to try to get us on to delivery system reform without us writing a stupid report this says everybody ought to be in Kaiser Permanente.

[Laughter.]

MR. HACKBARTH: You know what I mean. It ain't going to happen, not in my lifetime.

So bear with us and let's try to figure out if we can come up with something. I'm under no illusion about the complexity and the political barriers. Maybe we'll decide

at the end it just isn't worth the candle. But let's go a little further before we...

DR. REISCHAUER: My contribution was simply to say that I don't think there's a way out of the virtual bind. And you can convince me that I'm wrong by going down to the next level and showing me how these people -- not the hospital but the other people -- are going to get paid and what they're going to get paid, just sort of an example. You don't have to do it now. And why, when they aren't part of the forced team, they will understand what's happening and all, or think it's fair.

MS. MUTTI: Maybe just a word would add some clarity now and we can keep playing this out in future meetings, too. But just to be clear, our vision of virtual bundling is that the Medicare payments rates would still -- the current ones -- would still go for each provider. There would be something like -- and this gets to what Nancy mentioned -- there would be some kind of withhold, some kind of reconciliation process. You understood that. Okay.

And then some reporting would have to coincide with this so you would know why you were not getting your withhold back.

DR. REISCHAUER: You were engaged in 10 episodes but it was part of a 100 episode of pool and the other 90 were bad. That's why you aren't getting paid.

MS. MUTTI: Right. We will play that out a little more.

DR. CROSSON: How opportune that I'm the next one on the list. However, I have to admit to being somewhat speechless.

DR. REISCHAUER: We've just enrolled everybody in America in your plan.

DR. CROSSON: Then we do have some budgetary work to do. Thankfully, I'm becoming smarter in that category.

I think Glenn said it exactly correctly, that what we're really looking for here are financial mechanisms, incentive systems, whatever you want to call it, within the fee-for-service system that have the effect of creating incentives to create different structures that could subsequently be paid on a population basis. Because whatever you want to call it -- capitation is probably not the right word anymore for political reasons -- but paying on a population basis is much simpler.

And anything that we do, and we've talked about

several over the years, of looking at episodic care and trying to incent efficiency within the episodes, however good that is, it still leaves unaddressed the issue of how many episodes and opens up the possibility for gaming.

I think while I completely support this notion for the reasons that Nick has said and Glenn and even Bob has said, I do think we have to be -- this is really about creating new organizations with appropriate incentives because new organizations without appropriate incentives have the potential to make the situation worse. I think we've battled that issue in some ways already on the Commission.

I do think the notion on page eight that even if we select high cost, pretty major, not that common and discrete conditions for this, we still I bet, if not well done, open up the possibility for gaming and increasing lower intensity hospitalizations for congestive heart failure, for example, that might have been able to be managed by a good disease management process and a nurse.

And so I think as we go through this, we need to spend some time on what was said to be improvements in regulations and incentives to discourage the growth in

admissions. Because I don't know offhand exactly what that might be.

I think unless we do, then we're going to run smack dab into the political injections when we try to deal with existing regulatory obstacles because it will be thrown up very quickly. And even if we get past that, we could end up creating a system that has consequences which are actually opposite to what we intend.

So I really think we need to spend time working on that. And the whole viability of the notion could hang on that.

DR. CASTELLANOS: First of all, I think it's really great work and I really appreciate that.

Just to emphasize what Nick said on the glide path, I think one of the first things you have to do is the regulatory issues. As you well know, New Jersey Medical Society tried to get some gain sharing done and that was turned down by the state court system. I think you need to look at that, and maybe David could give us some idea whether that's even feasible.

I think we all have to understand what we're doing now isn't working. It isn't working very good. We may go

down this path and we may have a lot of bumps in the road, and we may hit some curves, and we may hit a stop sign where it says no. But we have to go there. We have to see if this works. We have to get the physician community and the hospital community together.

This is why I stressed this morning where Jeff's work on the high-quality, low-cost hospitals.

I don't know how you're going to get the AMA and the AHA on the same table. I can't even get them in the same hemisphere, they're so far apart. But that's not our problem. Our problem is to do the right thing. And I think that's what we really need to do.

I have a feeling, and it kind of bothers me just a little bit. We're looking at a good path to look at, but we're starting by looking and trying to find a crook behind each tree. Yes, there's going to be some issues on stinting, there's going to be some things like that. But let's not make that an impediment. There isn't a crook behind each tree.

Thank you.

DR. MILSTEIN: I agree with prior comments, that this is a very nicely laid out analysis. You really pointed

out all the pros and cons of most of the policy variables. I think the glide path toward bundling via virtual capitation is workable. There are some preceding models for how we might do it.

I think the idea of incepting it all with the hospitalization works well because most of the money that we're spending is for patients who are at high risk for hospitalization.

My comments, I think, actually reinforce a number of the comments that were made previously so I'll just touch on them lightly. We don't get that many opportunities for major change like this, where there is general consensus that average performance ain't good and we need to do something. We have it now. And so we want to make sure that we don't squander the energy that's there and the dissatisfaction with the baseline.

For that reason my inclination is, I think I said previously, would be not to be overly modest in figuring out what the geographic unit ought to be. If we thought we could move toward the total spending over the course of a year for any patient, a year subsequent to a patient rehospitalization, I would be in favor of it because it gets

us out of all the problems of a repeat episode.

And if we decide that that's not doable, then I would be in favor of more flexibility in terms of the geographic -- I need more sleep at night -- the time interval of the bundle so that we don't force advanced delivery systems down to the lowest common denominator which I think we have here, which is hospitalization plus 15 days. It's just too short and it deprives delivery systems that are prepared to take on a whole lot more longitudinal responsibility than that.

One idea would be to allow -- to take a page out of the CMS paper that we just read and let every provider determine what longitudinal unit they want to bid on and let the unit of comparison be whatever their baseline was but making an exception -- as Glenn has tutored me on the phone on this issue -- make an exception for those delivery systems that are already America's Toyotas. Don't take those delivery systems that are already top decile in terms of low spending and high quality and say your opportunity is only to improve upon that. I would be very generous with the very top tier, and then let the rest of them run against their prior baseline. It creates problems but it solves a

lot of problems in terms of fairness, I think.

I would err on the side of encouraging delivery systems to reach for total per person spending over the course of a year and see if we can -- that's really what I want America's hospital managers and physicians to be obsessed with. How do we achieve better health with lower per person per year spending? That's what we want. Again, I think there's some private sector models that provide some precedent for how we might do that.

And last but not least -- actually, this is a point I made earlier, that this is a complex system. And to the degree you can easily explain what this is all about, it's a huge advantage. I think to the degree we were to say to professors look, it's whatever your baseline was plus an opportunity for the hospital and their participating physicians who agree to this to take accountability with the hospital, it's improvement on your baseline that we will gain share with you around, obviously subject to quality simultaneously.

It isn't like we're starting from scratch. We have all of these demos that have been evolving over the last five years, and a lot of them -- we know now in

retrospect -- had some design flaws. But that's the beauty of starting now, because we have all the learnings from five or six years of Medicare demos, most of which are aimed at this issue of for a very high-risk population reducing total per member per year spending. We have a lot of learnings to build on if we allow ourselves to reach for this more ambitious longitudinal unit.

MR. HACKBARTH: Let me just put a place holder for one thing that I'd really like to think through between this meeting and the next meeting. I haven't thought of this as the only new payment model that might be offered. We've often talked, Nick has talked to us some about the group practice demo model which is very much what you're talking about, Arnie, where it's population over a year -- albeit still within the basic fee-for-service construct. So that's another stepping stone between where we are today and a full capitation approach.

My interest in this has not been at the expense of my interest in the group practice idea. I'd like to see if we can think how they can exist as alternative paths within same system. So for the most ambitious organizations, the most organized systems, you don't have to go backwards to

start here. We've got an advanced path for you.

I think we'll get into some of those selection issues again, the most advanced ones having lower cost structures and how do you avoid that, not increasing outlays. But I'd like to work through if we can have a couple of paths to walk on.

MR. DURENBERGER: I'm glad you said that because I was going to say something similar but in a different context.

First, I would just endorse the work of the staff. It is really very good, and it makes this whole thing much more understandable.

Secondly, to endorse all of this discussion today. It's terrific.

And then to endorse the continuation of your debate. Whatever is going on behind the scenes I think is very, very healthy.

And then to endorse what Arnie just said about what is our Toyota? To some degree, it's probably already been invented. There's probably several things out there that have already been invented, like capitation. We've said it doesn't work, or it didn't work, so we're not going

to give it another chance.

But for presentation, two thoughts. One, I think the most important way to present all of these issues is in the context of the doctor-patient relationship. So when we start a discussion like this, rather than starting it with efficiency or something like that, we ought to start it with the doctor-patient relationship. We ought to talk about the benefits to the beneficiaries of that relationship, and the benefits to the physician in the doctor-patient relationship.

Each time, whether we head down this one or one of the alternative courses, I think it would really be helpful to us because that will inform a lot more people about what we are doing.

That means basically we're realigning incentives. We have to realign not only the physician incentives and the hospital incentives, we've got to realign mine in this whole system, as well. When we think about what's the vehicle by which we do that, whether it's payment system or delivery system or something, keeping in mind the business of the aligned incentives as we articulate what are the values of bundled or bundling or something like that, I think is

really important.

And then finally, just putting this in the context of what we're going to talk about next and what we're going to talk about tomorrow morning, to add just one thing to the issue of -- this is in the context of delivery system reform or something like that. So is primary care. So is this and so forth.

But the one word that it would pay for us to add in there some place is accountability. Because if we are going to say this is about incentives and that sort of thing, we really need to add reforming the accountability and how does this match that as a principal?

MR. HACKBARTH: That's my favorite word, accountability. We're trying to build a system that has clear accountability for the results that we all care about.

DR. BORMAN: I would echo that I think this is obviously elegant work that's been very nicely presented. Just a couple of thoughts.

First off, I don't know that I'm convinced that we're going to get it right the first time we lay it out. I think we have to give ourselves some freedom to posit models, including models that will fail. I think we have to

be mindful of what Bill Scanlon has said about embodying models in law because they are difficult walk away from. But I think if we don't allow ourselves some room to be wrong, we will inhibit our ability to get to somewhere worthwhile.

I think that we all need to be aware that regardless of our vision in moving forward, the market is certainly moving more rapidly perhaps than we will ever get to. It is becoming, I think, a reasonably evident trend that we're moving toward a dichotomous provision of care in the sense that we have the capability of doing some very entrepreneurial almost fee-for-service base ambulatory and short stay kinds of things and more complex things are certainly more migrate on the in-hospital side. And physicians are migrating into two populations and primarily doing one kind of work or another. That's happening regardless of what we say.

I think that this certainly has some of the benefit of this will primarily pull in what has become a more homogeneous group of physicians who are providing inpatient care, particularly of the non-major procedural side so that it gives us some possibility of working.

A couple of concerns about this. Number one, when we talk about somebody is getting admitted to a hospital today, they're a pretty sick puppy. This is not somebody that's coming in for the spring tune up to just get the executive physical and have some things tweaked. This is somebody who truly has some significant illness.

And I think if we don't at least get some data about some short time period before that, we'll lose a big chance to influence the system on what could have been prevented and some education to the individuals involved.

And I think, in addition to using payment to force organization, this sounds to me a bit that we're using a payment to get to an education.

A little bit, touching on what Bob brought up, I think when you report resource use, you're going to have to share something about the entirety of the episode for the individuals to know, to become agents of peer pressure, but also to understand what they can do better. So I think you're going to need to know what the ED did versus what the hospitalist did or whatever and provide not just an individual's own use to him or her. But you're going to have to provide some fairly significant information of the

episode or that educational opportunity will be lost. If you don't have the educational opportunity, you're going to have anger and backlash and not education and peer working together result from it.

I am somewhat less worried, and probably naively, then some about that this will move things back into the hospital for inappropriate reasons. I think a fair amount has gone on in the background that will make that very difficult to do. I think there's a whole host of practitioners that only go to the office know or only go to the hospital. And the notion that all of a sudden you're going to flip that switch and they're going to change that, I think is less a possibility than it might have been 10 years ago.

I think some of the things we did inadvertently moved stuff to the outpatient setting. I'm not sure that it will turn around and react in exactly the same way. The market is different. The expectations of people finishing medical school and residency are different about what their lifestyle is going to be.

And while I have to admit there's clearly got to be risk, I'm a good bit more confident that there will be

some market and practitioner behaviors that will reduce that risk.

MR. HACKBARTH: Like Karen, as I listened to the conversation I was listening about Bill's earlier comments in the context of skilled nursing facilities and not having a reverse gear and the like.

So as we think about the path from here to there, wherever there might be, we've got a few concepts on the table for how to structure that path. One is the measured implementation that is shown on slide nine. That's one type of way to get from here to there.

Another very traditional one is demo first.

And the third is the pilot concept that was used for the disease management and now I think health support project, where for areas of the country it would be required. And then you would do evaluation and the discretion would be vested in the Secretary to move to implementation without having to go back through the legislative process again.

There may be some others out there. I'd like to sort of keep all of those in mind. They're not necessarily mutually exclusive. They can be combined to create a path

from here to there.

Good work. Thank you very much, and look forward to the next conversation.

Last, but certainly not least for today, is promoting the use of primary care. Cristina, Kevin and John are going to do it.

Welcome back, Cristina. We missed you.

MS. BOCCUTI: Thank you. It's nice to be missed, and nice to be back.

MR. HACKBARTH: You said that with less enthusiasm.

MS. BOCCUTI: The Commission has expressed interest in exploring ways to promote the use of primary care services and the professionals who provide them. By primary care we're talking about comprehensive, acute, and maintenance health care that includes coordination with other health services. Typically, primary care physicians are trained in internal medicine, family practice, and geriatric medicine. Advanced practice nurses, such as nurse practitioners, may also be providing primary care.

Today, Kevin and John and I are going to review the importance of primary care and its risk of

underprovision and then introduce an initiative to promote the use of primary care services. I'll first talk about medical programs with specific attention to design questions, and then John is going to talk about maintenance of certification efforts, and Kevin some fee schedule change ideas.

The Commission's SGR report included a chapter on ways to improve value in Medicare. One of those ways was to increase the use of primary care services and reduce reliance on specialty care. This goal can improve the efficiency of the health care delivery without compromising quality. Research from Elliott Fisher and colleagues show that areas with more use of specialty-oriented care are not necessarily associated with improved access to care, higher quality, better outcomes, or even greater patient satisfaction. Other research has found that nations with greater reliance on primary care have lower mortality rates on certain measures.

Despite these findings, Medicare's fee-for-service payment system provides no encouragement for beneficiaries to seek services, when appropriate, from primary care providers instead of our or before specialists.

Primary care services really do risk being undervalued. Previous MedPAC work has found that compared to procedurally based services, cognitive services, which are a hallmark of primary care, are less able to realize those efficiency gains. Thus, they really risk becoming undervalued and consequently under provided when physicians view them as less profitable. Further, we see a steady decline in the share of U.S. medical students entering primary care residency positions.

The first initiative we're going to discuss is medical homes. Broadly speaking, a medical home serves as a central resource for patients' ongoing terror. They're often associated with patients' primary care providers but patients could choose a different kind of specialist for a mate chronic condition such as endocrinologist for patients with diabetes. Medical home initiatives have the potential to add value to the Medicare program. Ideally, through better care coordination, medical comes could enhance communication among providers and thus eliminate redundancy and improve quality. They may also improve patients' understanding of their condition and treatment and thereby reduce patients' use of high-cost settings like emergency

rooms.

Another important goal includes enhancing the viability of primary care practice.

In its June 2006 report, the Commission discussed care coordination programs, which is a major component of medical homes. Through literature reviews and interviews we found two functions essential for good care coordination, namely care manager -- usually a nurse -- and that person assists the patient in self-management and monitors patient progress.

The second is an information system to identify eligible patients and store and retrieve patient information and share information with those who need it. We also found that integration with the patient's physician was key.

So the details of designing and implementing a medical are numerous and involve trade-offs. Your mailing material included 10 questions on implementation but today I'm only going to select five of them because of time. We can, of course, discuss others if you'd like during the question-and-answer period.

I also want to mention that CMS is grappling with some of these issues, too, as it's in the design phase of

the demo, the medical home demo that was enacted by the TRHCA legislation

So a crucial question rests on our definition of a medical home. Frankly speaking we, meaning the staff here, have been in meetings and attended conferences where it becomes clear that people in the same room have very different concepts of what they're talking about when they talk about a medical home. So there does lack some consensus in the policy community about what really defines a medical home. So I think it's important for the Commission to first have a discussion about what exactly it's envisioning what it's talking about a medical home. And then when we get into the implementation questions we're all on the same page about our initial concept.

So in this slide I've listed dimensions that you might consider when defining a medical home. For example, do you define a medical home by the services it provides beyond the diagnosis and treatment, such as health IT and electronic medical records? Or do you further define a medical home by its size? Do practices need certain types of providers to be called a medical home? Are medical homes defined by their responsibility for overall resource use and

patient health outcomes? And finally, would an external body be used to accredit and thus define a medical home?

A major component for medical home design is its payment structure. This slide presents a continuum of payment models organized from left to right by the amount of financial risk borne by the medical home. Among these four payment models which are in the columns three concepts generally are in play: the size of the a monthly payment; whether or not the medical home could continue billing fee-for-service; and the amount of risk that the medical home takes on. So for example, would the medical home be at risk for Part A and Part B or just Part B, or none?

And of course, across all of these payment models, payments to medical homes could also be at risk for quality indicators.

An important question is whether or not beneficiaries would be able to seek care from specialists without a referral from their medical home. On the more restrictive end of the continuum, a referral could to be required from the medical hope to see all specialists. Or for a medical ground, one might consider certain specialties such as gynecology for women to be exempt from referral

requirements. And then on the looser end, no referrals would be required to seek specialty care.

This question is important and certainly involves trade-offs. Encouraging beneficiaries to seek guidance from their primary care provider on whether or not to see a specialist could result in lower spending, on average, without necessarily compromising health outcomes. Requiring referrals also gives more leverage and prestige to the medical home. However, beneficiaries may object to apparent restrictions on access to specialists. Similarly, some specialists may object that access to their care is being impaired.

If medical homes are at a financial risk for patients' resource use then they may need tools to influence specialty visits and referrals, as we were going through on the slide before.

Another consideration in designing a medical program is the size of the program and which beneficiaries could be eligible to participate. A targeted approach, say on beneficiaries with a selected condition like CHF, could focus efforts where they might be needed most and also allow the program to start on a smaller scale and then grow more

slowly. However, opening up the eligibility pool encourages beneficiaries to establish relationships with their medical home from the beginning of their enrollment in Medicare.

Finally, some have suggested that in order to promote the use of primary care services we should consider beneficiary incentives. Such incentives could go toward joining medical homes or for seeking primary care services in general. For example, beneficiaries who join medical homes could have a reduced monthly Part B premium. They could also have tiered cost-sharing for fee schedule services, say 15 percent for primary care services and 25 percent for specialty services. But these differences are, of course, mitigated for those who have supplemental insurance, which is most of the Medicare population.

Medicare could also undertake public education efforts to inform beneficiaries about the benefits of primary care, and, of course, of medical homes.

John is going to take you through our next section.

MR. RICHARDSON: Thank you, Cristina.

I'm going to talk about maintenance and certification programs that are another option that Medicare

could consider to promote the delivery of high-quality primary care services to Medicare beneficiaries. First, I'll describe what MOC is and then go over some options from Medicare to use maintenance and certification to promote primary care.

MOC programs are voluntary continuous professional developing programs that have been developed over the past few years by small but growing number of the physician specialty boards that are affiliated with the American Board of American Specialties, or ABMS. MOC programs build on the traditional board certification process, under which a physician must have valid unrestricted medical license, must pass a comprehensive formal examination of medical knowledge and clinical judgment -- typically every 10 years -- and must periodically test the currency of their medical knowledge using board approved self-examination tools.

MOC programs incorporate all three of these parts of the traditional process but add a key new component, self-evaluation of the physicians' practice performance. The details of this component of MOC programs vary based on the specialty board that's developed the program but all of the programs are developed according to general criteria set

forth and maintained by the ABMS and the Accreditation Council for Graduate Medical Education.

The MOC program developed by the American Board of Internal Medicine provides an useful illustrative example of the practice performance self-evaluation processes that make these programs distinctive from the traditional Board certification process. So we'll give you a quick overview of the ABIM Practice Improvement Modules. The ABIM has developed 15 practice improvement modules that range from condition specific, such as treatment of patients' diabetes or hypertension, to practice structure and systems, such as how the practice communicates with subspecialists or manages its hospitalized patients.

Basically, the participating physician or group practice works with the ABIM through a web-based tool to analyze its current prices and outcomes, identify areas for improvements, and then reevaluate its performance after redesigning some of its processes to achieve the desired performance goals. The ABIM determines whether the physician or group has satisfied the program's requirements and should be designated as having completed the module and thus receive credit card toward maintenance of his or her

board certification.

For Medicare, the self-evaluation aspect of the practice improvement modules or other MOC programs equivalent processes raise an important policy issue about where the ultimate locus of responsibility and accountability should be for ensuring that physicians or groups have met the program's requirements. This is one of the issues that we will be looking into in more detail as we research this further.

How could Medicare use MOC to promote primary care? One approach Medicare could consider would be to increase payments to physicians who meet MOC criteria from the primary care specialty boards that have developed MOC programs, which currently includes the ABIM and the American Board of Family Medicine. Payment increases could be implemented through a pay for performance program or through an across-the-board increase in payments to physicians who have met Medicare's designated MOC requirements. In either case, the payment changes could be made in a budget neutral fashion by decreasing payments to physicians who do not meet the designated criteria.

It's also worth noting the potential impact on the

quality of primary care services that recognizing and working with MOC programs could have on those services.

There is precedent for this activity. Over the past few years some private health insurance payers have begun incorporating primary care MOC programs into their pay for performance and other provider recognition programs. For example, the Aetna Mid-Atlantic region recognize certain network primary care physicians in the plan's provider directory if they are enrolled in ABIM's process and if they have completed ABIM's diabetes practice improvement module. Qualifying physicians receive credit towards their performance scores under Aetna's pay for performance program, as well as being recognized in the provider directory.

Other payers that are recognizing aspects of ABIM's MOC program in particular include the BlueCross BlueShield Association and some regional BlueCross BlueShield plans, CIGNA, Humana, United HealthCare, and the Detroit-based Health Alliance Plan. MedPAC could analyze these private payer programs and determine what components of them are adaptable to Medicare's fee-for-service reimbursement system. We would also want to assess their

compatibility with other Medicare program changes recommended for being considered by the Commission, such as implementing physician pay for performance or measuring physician resource use.

One potential policy concern is that MOC requirements could be weakened if Medicare decides to base payment increases on individual physicians' participation. Medicare's recognition of MOC for payment purposes could put pressure on certifying boards to dilute the standards for their programs so that more physicians would qualify for the enhanced payments. To address this concern, Medicare could create its own process for reviewing and approving MOC programs, or could adapt a third-party evaluation framework such as the one currently under development by the National Quality Forum.

Next, Kevin will discuss options for the physician fee schedule adjustments that could be used to encourage more primary care.

DR. HAYES: Thank you. With some changes, the current fee-for-service payment system for physician services, the physician fee schedule, could be a tool used to pay for medical homes and reward careers in primary care.

One way to do so is to increase the fees for specific services in the fee schedule of services such as visits. This is what we mean by the fee schedule adjustments listed first on this slide.

We have some new ideas to discuss on this and I'll get to them in just a minute. Before doing so however, it is worth recalling that the Commission has already considered some policy changes that could help reward primary care. Time prevents me from reviewing each of them in detail. Let me just say that some of the policy changes you have discussed would indirectly increase payments for primary care. I say indirectly because the fee schedule is budget neutral. Decreases in fees for some services result in redistribution of dollars to other services. Decreases in fees for specialty care and, therefore increases for primary care, could incur as a byproduct of three changes in policy the Commission has considered: improving the five-year review of relative values for physician work, improving the accuracy of payments for practice expense, and automatically adjusting relative values for services with rapid growth in spending.

By contrast, the more direct way of increasing

payments for primary care could be through use of comparative effectiveness information. We would expect primary care services to compare better in their effectiveness than many other services. Because of this, primary care could garner higher payments if comparative effectiveness information is used to inform the level of payment.

Another fairly direct way to intervene would be to have an expenditure target structured on type of service. In other words, a type of service SGR. While not listed here, such a change in policy is discussed in the Commission's SGR report. As the report shows, with a type of service expenditure target if primary care services have a primary growth rate that is lower than their target, they could get a higher update.

So there we have a kind of summary of some of the ideas that you've discussed previously. Now let's move on to this idea of fee schedule adjustments.

Briefly, they can include either adjusting fees for selected services or further targeting the adjustments toward not just selected services but also specifying that the adjustments are available only to selected specialties

and those furnishing a medical home.

Let's look first at fee schedule adjustments that apply to selected services. The adjustments could occur through the conversion factor with a conversion factor that is higher for primary care than for other services. Another way to implement the adjustments would be to define new services in the fee schedule and assign relative value units to them that are high enough to reward primary care. Either way, the adjustments would depend only on the service billed.

The difficulty here -- and Jack, this gets us to the chart that came up earlier when you were asking about billing for E&M services by specialty. The difficulty here is basing the adjustments only on the service is that it is a somewhat efficient way to adjust payments for those furnishing primary care. Depending on the service, many types of physicians and other providers could furnish the service eligible for the adjusted payments. For instance, we see here that in the case of office visits, physicians in multiple specialties furnish the service. The two specialties that account for most of the billing for these services -- internal medicine and family practice -- are

typically thought of as furnishing primary care. Nonetheless, much of the billing for office visits is attributable to physicians who also furnish more specialized care, such as those in cardiology and orthopedic surgery. If a payment adjustment were based only on the service furnished, physicians in a number of specialties could receive the adjustment along with primary care physicians.

To target the adjustment toward those who furnish primary care, it is possible to have a policy that considers not just the service but also specialty and whether the service is furnished in a practice with at least some of the features of a medical home. In specifying which specialties are eligible, the specialties could be say internal medicine, family practice, and geriatric medicine. Other specialties may step forward, also. In addition, there could be a decision that advanced practice nurses are eligible for the adjustments.

As to basing the adjustments on whether the services are furnished in a medical home, Cristina spoke to that topic, of course, so I will not go into it here but we hope that there is some further discussion of the points that Cristina made. For now, let me just say that there

would need to be say a performance measurement system that would allow physicians to attest to furnishing a medical home.

To summarize then, we are talking about fee schedule adjustments that would have requirements in three areas: one, what services they are and whether they're eligible for the adjustment; two, the specialties receiving the adjustment; and three, the medical home. A payment adjustment would occur if a claim meets the requirements in all three areas.

In submitting a claim for payment, those billing Medicare could say that they have met these requirements by including a special code number -- known as a modifier -- with the billing code for the service furnished. Modifiers are used in the payment system now to adjust payments for such things as receipt of a bonus for furnishing services in a health professional shortage area. The presence of a primary care modifier on the claim would trigger an adjustment which, as a multiplier for a service's RVUs, would bring about higher payment.

With such adjustment, an issue to resolve is how to reliably determine physician specialty. Physicians

declare a specialty when they apply to bill Medicare. However, they can change their information when they add a billing location or for some other reason. With payment adjustments that depend partly on specialty, further policies may be needed that would define what specialty means and to set criteria for a change in one's specialty.

To conclude, it is worth observing here that the fee schedule adjustments we have presented represent a change in the underlying intent of payment for physician services. Adjustments that considers say specialty and medical home would be different from the current system, which tries to account for differences among services and resource costs but, as we have seen, does so in a way that is not without its problems.

Instead of accounting for just resource costs, adjustments that reward primary care would be a way to achieve other policy goals. Doing so would require the exercise of judgment, however. Instead of a formula, as we have now, decisions would be necessary to set the level of the adjustments, basing them say on the availability of budgetary resources.

That concludes our presentation. These are the

key points that we covered. We look forward to your discussion.

MR. DURENBERGER: Thanks very much.

I've already made reference to this in my previous comment, the context comments, that looking at the importance of primary care and its risk of under provision is a really important element in redesigning health care delivery. But commenting, if I may, on the presentation the way it's presented, it seemed like we got very quickly into the medical home. We got very quickly into the solutions. And I'm going to suggest that perhaps we spend just a little bit more time defining primary care in the beginning or do it perhaps in a different way.

The first question is what is it? It's physicians, but it's also a lot of ancillary health professionals. It's also cognitive and a lot of these other things you've talked about. But then there's a variety of these specialties. Some of them have been mentioned, geriatrics and mental health and behavioral health and oral health. There's just a lot of things that will help people understand the breadth and the depth of the services. So that when we talk doctor/patient relationship, we're

reminded that primary care is all around us and it has a higher value than most of us give it, and certainly a higher value than third-party payers give it.

The second thing is why is it important? Simply stated, it's like health maintenance and care coordination. Because it's at that level that we expect to get the professional advice we need on health maintenance. Whether we take it or not, that is the level of expectation that most of us resort to. Ask any mother who is just having a child, or particularly if it's their first child. That's where we go.

Third, the problems with it, which are in part alluded to here. But I'm trying to think of it in a different way to present it. The first is a quality problem. That's the way I look at the overvaluing of specialty medicine and specialty services. The result of that, of course, is that supply induced health care delivery, which is called overuse by the Institute of Medicine and a lot of other people. So we have a serious quality problem with the current system.

As you point out, we also have an efficiency problem because we really haven't defined value and how we

pay for it.

Thirdly, the way I define productivity, we have a productivity problem that comes from professional barriers to primary care. The last time I went in for my physical, I'm sitting there with my internist and my computer and all my information. I say what's the next thing you're working on? He said we're trying to break through the grasp that gastroenterology has on diagnostic colonoscopies but they won't let go. Well, you can take this to anesthesiology and nurse anesthetists. You can take it through all of these professionals. I think it is worthwhile -- again in the context of what is value in primary care -- to lay out some of the barriers that the professional associations over time have built to getting value from primary care.

The fourth one then deals with education. Clearly, we're over educating a lot of physicians, in particular, and we're under financing education in this country. There's no doubt about that. We're driving people away.

But a third factor that we learned exploring whether or not our university ought to get into the medical school business is we are admitting the wrong people to

medical schools if we expect a family practitioner or a community health person physician or a geriatric specialist to come out the other end. We need to be admitting into the medical schools of this country and using whatever our financing techniques are to reward a different kind of a person, largely being -- and Tom Dean taught me that and he sent me to a professor at the University of Nebraska. We need to go to the same place that all the universities go to that want health professionals. They go to the same people that want to go into the ministries and that want to go into other caring professions.

So I think it -- I know our business is financing access and how do we change the financing of the access. But in terms of making the case, whether it's for the medical home or these other solutions we have, it seems important to be making a case for primary care and its importance, whether it's the geriatric population like me or it's some other population, and showing the existing barriers that seem to favor the more specialized approach that also need to get taken down.

DR. CROSSON: I'd like to start by complimenting the staff for laying out these ideas. We have said we want

to do something about the primary care problem. It's a lot easier to say we want to do something then it is to figure out how we would exactly go about doing that, although we have made some, I think, progress on the payment side.

With respect to the medical home thing, it seemed to me -- and I'm at the risk of oversimplifying here. But I have heard John Tooker present a number of times and others, and remember actually when the American Academy of Pediatrics first started this notion. What I thought this really was was the idea that primary care physicians, mostly in small practices, using information technology and team-based care, using ancillaries, could be enabled to improve quality at least -- the issue of efficiency, I think, has been hedged a bit -- but improve quality through better coordination of care. And that many small practices just don't have the time and money to invest in some of these tools, whether it's information technology or different types of communication with patients by phone or through the Internet, unless they have some financial resources to do that. And that was essentially the proposal.

As the notion was laid out here, and I suspect this has something to do with some of the discussions that

are going on around the CMS project and NCQA and the like, it does appear to take this in a rather different direction. And to me -- we can call it anything that we want to -- but it doesn't really sound very much like the original notion. It sounds to me more like it's heading in the direction of a euphemism for an accountable care organization.

Because when you start talking about issues like risk bearing for hospital services, you can't do that at the level of a small practice. You can't even do it really at the level of a medium-sized practice. It takes a significantly larger organization. I think if you're talking about even capitation for physician services, and certainly for capitation for specialty services at the primary care level, you're also dealing with a potential ethical concern. I would never promote that sort of pre-payment. And also, if you want to throw in there the gatekeeper notion, then we really have a back to the future element here.

I'm just concerned about us following down that direction. Unless we really think that what we've got going on is a set of discussions which are eventually going to lead back to the same place we were talking about a little

while ago, which is the need to create coordination at an integrated institutional level, in which case we ought to say that.

The last point is just on the maintenance and certification thing. I think I agree with the point that was made, which is that this direction is going to have to, in the end, include most of the physicians in the specialty. I don't really think it's going to be broadly supported over time if it, in fact, starts to exclude a significant portion of the physicians in a specialty.

So if we assume that that's the case, even without linking it to Medicare, then I'm not sure I get why we need to connect -- because in the end if we're going to reward the physicians who succeed in maintenance and certification through the Medicare program, then we drop to item three which is how we're going to pay them. What the payment increases would be based, which is the third consideration.

And if you assume that most of the physicians in primary care are probably going to be successful in maintenance and certification, then we've just created I think a lot of complexity to what otherwise would be just simply increasing the payments.

MR. HACKBARTH: Can I get you to react to the first point about bearing of financial risk and whether that's consistent with the medical home model?

MS. BOCCUTI: My first reaction I think is analyzing a policy or a program like this, it's important to look at the whole continuum. That's why this is up there. So you could say that that's not defining a medical home. The Commission doesn't think that a medical home is one that takes on risk for Part A and Part B.

Then if you keep moving down towards the right on this continuum, you get to no risk or some share of fee-for-service spending. If they got a monthly fee, that could only go for the medical home activities.

So there are spans, I think, within the model that I'm hearing from you, a payment mechanism. Is that where you're going?

MR. HACKBARTH: As I understand the medical model that ACP and the family physicians and others have been talking about, there is a monthly fee but no insurance risk. The purpose of the monthly fee is to cover expenses, as Jay said, that aren't paid for under the fee-for-service system. Those could be expenses related to infrastructure like

clinical information systems. They can also be for physician and nurse practitioner and other services provided to the patient but are currently not recognized for payment, educational activities or telephone consoles or e-mail consults and the like.

Part of the idea, as I understand it, is that when -- for example, paying for e-mail consults has been talked about. There's some very obvious problems that that raises. You'd be talking about small payments, incurring lots of claims processing expense and big issues of potential fraud and the like. And so they're suggesting let's bypass that. It's not an activity that's appropriate for a fee-for-service payment. But there may be still real value in it. So let's use a flat per patient payment as the vehicle.

But it's very different from the old primary care capitation model, which proved so problematic in the 1990s, where physicians were asked to bear financial risk for referrals and drugs and hospital services.

MR. BERTKO: I just wanted to say, I think I interpreted Cristina's comment exactly right. She presented a continuum and then -- I'll take Jay's comment and earlier Bob's impossible comment, and say this glass might be half

full rather than half-empty. You pick that third column there and say let's look at the primary care fee models that happened in Medicaid, this is it. We could actually do this in a year-and-a-half. The third column, the risk-adjusted.

There are models in Medicaid. You take a year to define it and you turn it on 1/1/10, and we have something. With the goal that we all explicitly or implicitly say. This is all morphing towards ACOs some day. But this would begin setting up some of this infrastructure. So in that sense, Glenn, you just described most of the decisions that would be made. There just needs to go through the process to get there.

DR. MILLER: I would also draw your attention to the bottom of that third column. It does involve some risk, which a lot of people are not talking about the medical home doing. All we're trying to do is force this conversation.

You said, Jay I'm uncomfortable with these two columns over here. You've talked just to the third column. There are people who I think are still pretty uncomfortable even with the bottom part of that next to the last column. This is the conversation we need to have.

DR. REISCHAUER: [off microphone] The bottom

could also be bonus payment at the end of the year based on all of the book of business.

DR. MILSTEIN: I think it would be helpful for me just if there was clarity as to what is a job we're trying to do? One definition of the job is to stay look, despite our best efforts primary care fared very poorly over the last 10 years and we want to, on a one-time basis, reset.

The second idea, which is more what we're talking about now, it could be a completely independent idea, is do we want to begin to incentivize a more robust variant of primary care? I just want to point out, those are two different jobs. It would be helpful for me to just maybe have clarity as to are we trying to get both jobs done? Or can we do one and not the other?

MR. HACKBARTH: Your point is a good one. They are different jobs. In the full range of the presentation there were some ideas discussed that would address each. The medical home idea is more about changing the structure, building a structure. An example of the other is type of service SGR. It's strictly a redistributional device. It doesn't try to change how the services are divided. It's let's divide the money differently. And then some of the

other proposals may fit somewhere in between on the continuum.

DR. REISCHAUER: I'd like to say it's not clear that these are totally separate because a lot of what medical home is going to do does go on now and is not reimbursed. So it sort of kills the two birds with one stone.

DR. CASTELLANOS: I like the idea. I really do. I think, from a physician's viewpoint, what we're trying to do is enhance the respectability and the desirability for primary care. One of the ways we can do that, again I'm going to be repetitious, is starting in the medical school right from the get-go and talking about the goals that we have talked about in our core programs and getting the medical school student right from the beginning interested in primary care and the value of primary care.

However, the viability is going to be tied to and related to reimbursement. And we really need to, as we all discussed earlier on many times, we need to increase the reimbursement issues for the primary care. We can do it through the medical home or the E&M charges. How do we do it? What are the payment schedule changes? I would

certainly avoid the RBS's. I really would. It's a domino effect and it would affect too many other issues.

I think it would be much easier to do with a conversion factor or a modifier, as we do so often.

One of the things that Dave said earlier is what are the goals? We need to start not from the top down but right where the patient is and work from the bottom up. I think once we go there, I think it's going to be pretty easy to work out a lot of the goals.

As far as referrals to specialties, again I think we knew what happened in the 1990s with the HMOs. I would certainly suggest maybe a cost-sharing progressive increase to see specialties.

DR. WOLTER: Most of mine is a pick up on some things others have raised, but I too thought we had sort of a couple major themes unfolding in this chapter. By the way, I think it's really excellent in terms of it outlines some of the questions we have to answer. One is promoting primary care, and the other really is coordination of care. I think those two circles highly overlap but they don't 100 percent overlap.

So how do we want to draw that distinction? Are

we primarily focused on the patient here who needs coordination of care? Because I think that leads to a slightly different list than if we're primarily focused on better reimbursement for primary care patients.

And I'm very supportive actually of the idea of a medical home and of primary care docs being in the thick of that and giving them incentive to kind of do a better job on some things that can really make a difference to patients.

In my own organization we're doing a lot of this, but it isn't focused only on primary care. Our cardiology department runs our congestive heart failure clinic and the patients who go through that actually might have a primary care doctor. We often try to keep them seeing that doctor. But in between these visits actually the key players are nurses. And they're not always advanced practice nurses. But that's really where the rubber hits the road in managing these patients between doctor visits.

Also, we have found that, for example, the importance of registries is really high. Most practices really couldn't, if they were asked, on the same day pull out a list of all of their diabetics. It took us six months to rewrite some software for our new IT, which I've

mentioned here in the past, to be able to know who our diabetics were and then to be able to give our internists lists of all of their diabetics so we could start holding them accountable to getting diabetics all the appropriate measures. It's been an incredibly valuable program since we put that together.

But there's a lot of intersecting pieces. I think the major point I'm trying to make here is I think however we define the medical home, there are some infrastructure standards that will need to be in place. And I think some of those can be met by small practices. For other much more complex patients maybe it will be more difficult. But to me that would be key if one of our goals is better coordination of care, in addition to incenting development of more primary care providers.

So I think the distinction there and how do we want to position this chapter is really important. Do we really want to coordinate care? And then within that, primary care is a major thrust but there are going to be some other options. Or is it primarily about primary care development and how it can coordinate care, and we can deal with the other approaches sort of in another place?

I think some clarity might help us there.

MR. HACKBARTH: Helped me, Nick, think about that. As you know, there are a number of existing Medicare demos aimed at the broad issue of care coordination, for example the health support demos that identifies patients with certain costly diseases. They work on that care coordination plane. It isn't primary care, it's patient focused, disease focused. And so the way I sort of fell into this conversation, not through reason but just by accident, is more thinking about primary care.

To get back to Arnie, I think of the tasks being both tasks, to increase payment for the specialty to improve its relative attractiveness, but also help to build infrastructure so that primary care practices can do their job better or pay for infrastructure that exists but has been uncompensated in the past.

So I'm thinking of primary care, not so much care coordination.

DR. WOLTER: We're going to pay the primary care doctors for something, and it seems like we're talking about care coordination.

MR. HACKBARTH: They cross, absolutely.

DR. WOLTER: So I'm just saying that that's great. I am 100 percent supportive of it because I think that's a great place to do a lot of this work. But there is an infrastructure need around mid-level providers and registries. And then there's an accountability issue. Even if we're not holding people at risk for the annual cost of care for a beneficiary, will we be able to track that this work actually does a good job starting to deal with that? I think we'd want to do that. We'd want to at least provide the information.

Now we are into care coordination. So do we want to allow group practices to be medical homes? Or groups of cardiologists if you've got somebody with congestive heart failure and hypertension that needs cholesterol control and you can do it very effectively.

I just want to think through some of the nuances of it. That doesn't mean I'm not 100 percent supportive of really trying to create a lot of emphasis on primary care.

DR. KANE: First, I wanted to say I am very supportive of the medical concept and just recognizing primary care and paying for what they do would be terrific, however we do it.

But what I'm thinking about as I listen to the discussion also about the bundling and the A and B is how many reforms can you start at once? And is there some better than others to start with? Do we want to start on the acute side with the Part A/B bundle and watch that blow up politically? Or do we want to start with something that has an earlier win like a medical home or chronic disease management payment?

I'm just thinking, one of our alums is a German -- he's the head of an institute that's now involved with health care reform. And they just implemented a giant nationwide disease management program for diabetics, paying every primary care doctor a certain amount to be willing to be in the protocol, and then paying the patients to sign up. It's been in place for about three or four years and it's had huge impact so far on the evaluations.

Those are the kinds of things where early wins are kind of simple, they're kind of easy. It wasn't easy, he'll still tell you it's not easy.

But I wonder if we're going to eventually look at all of these and try to rank them by where we really want to start? Is bundling in A and B really the place to start?

Or is it more in this chronic disease management primary care? And then is it everybody or is it the chronically ill already? It would be nice to start that way. I feel like we're getting into the details before we kind of know where our big wins are likely to come from.

And my only other question is -- I think I did this before, so I'm going to start like a broken record -- but is Part D part of any of this? Or is that just outside, kind of running along on its own lack accountability or whatever? Do we want to start making -- certainly you'd think that for chronic disease management, if you can't include Part D utilization, and how will that be brought into the payment model and the responsibility model?

I feel that's been left out of the bundle for A/B and also the medical home. Where is Part D in all of this?

MR. HACKBARTH: Let me just react to the first part of what you say, Nancy. It's a really important point. The system -- system broadly defined, MedPAC, CMS, the Congress -- has a finite and distressingly small capacity for change. We've noted that from time to time.

So one way to conceive of our task is to say well, we need to set priorities like we ran this system and we

managed the resources and so here's the path. This is the top priority, this is second, this is third, and the like.

I don't think that's the right role for MedPAC to be in, for two basic reasons. One is that although we're all vaguely aware about the system capacity and limits, we really don't in many meaningful sense understand the system capacity. So any judgments we made about what could be done would be really seat-of-the-pants, ill-informed.

But even more important than that is a point that Mark has taught me, which is the policy process has a certain quixotic element to it. You don't know when the time is going to be right for a particular idea. And maybe the best way to think about the way we can contribute is to work on a number of important ideas. We ought to filter for importance but not try to be too rigid about this is first and this is second, or even necessarily how they all integrate with one or another in the final plan. We need to be opportunistic in creating ideas that can go into the policy process and if the conditions are right, move forward.

So I wouldn't try to be overly rational about what we do, although I understand the impulse. It's where I

live. But as Mark tells me, I need to sit back and relax a little bit and accept. He is clearly the role model for doing that.

DR. KANE: I feel you're already doing it with the Part A/B, saying here's the way the trajectory should work. I guess maybe we shouldn't spend a whole lot of time either worrying about whether we're virtual or mandatory because as you say -- what do they call it, the garbage can theory, the stars line up? How sausage is made, right.

I guess that goes back to how deep do we want to go into any of these ideas if it's really going to be a sausage -- oh, I don't like sausage.

MR. HACKBARTH: I do think there's a bit of a difference in saying here in concept is a path to get from here to a destination, as opposed to saying okay here's how many resources are required to do a medical home and here's how many for bundling and here's how many for something else. We don't know what those resources are. We couldn't make informed judgments about those things.

I do think it's reasonable to only talk about ideas we think are important. And then, when we talk about those ideas, to say here are some ways that you might get

from here to there. I do think those are reasonable steps.

DR. BORMAN: First to say a couple of things about MOC. I would tell you, and you might want to verify with ABMS, but this is not an entirely voluntary effort by a few boards. All 24 member boards of the American Board of Medical Specialties must be in the process of implementing MOC. This is not some little mom and pop show by a few boards. This is all boards, in order to remain member boards of the ABMS, are at various stages in their MOC development. MOC has some standard pieces, parts one through four, that each board must address. And each board must get its MOC plan signed off on by the ABMS. So just to give a little background about MOC.

In parallel, there is an effort going on that's under the leadership of the Federation of State Medical Boards that relates to MOL, maintenance of licensure. There are some pieces of that, as well, that will relate to all physicians.

I would like to just offer a note of caution about integrating this too tightly, MOL or MOC, in anything we propose. This has got a lot of rapidly moving parts. And while I think we all want to look at various quality

designators -- and I, for one, believe that Board certification is a quality designators -- I think we want to be a little bit careful about getting so far down the road as saying this might be a way to attach payment or whatever. I just regard that as very premature and I would offer some caution on that.

Relative to the issues of payment favoring primary care and the medical home, that kind of thing, trying to tease out what it is we're really trying to represent here as I listen to this is something -- I think maybe what characterizes it is the deepest or the most ongoing doctor-patient relationship. I think doctor there, as Nick has pointed out, may be doctor plus. And very often various ancillary individuals are a piece of that team.

If that's the case in what we're really seeking, then I think that it's -- I'm not sure whether it's best connoted by primary care, medical home, or what it is. I was only urge that we try to come to some agreement about what four or key elements of it are. Just like was said in the presentation, every time I hear somebody talk about the medical home I think I hear new twist on it that I didn't hear from the other folks.

In my view, a few of those things might be if this is indeed marked by the depth or breadth or longevity of the doctor/patient relationship, it relates to care coordination. It relates to 24/7 responsiveness. And I don't hear that necessarily coming out in most discussions of the medical home. And I think if the medical home is going to have any impact, it's going to have a take on 24/7 responsiveness. I would urge that as a feature of it.

Another is that I think a huge cost area of the Medicare program and health care in general relates to end of life and futile care. And I think one of the pieces of this relationship needs to use that somehow as a marker. And whether that's something as simple as your medical home and you document a conversation about your advance directive wishes or something more sophisticated, I really don't know. But that seems to be, to me, another very important element of this.

I would like to echo Bob's comment about maybe considering this in the form of a performance based bonus over a period of time based on an aggregate of patients and their outcomes, as opposed to trying to attach this to individual services or individual patients. I think all we

do there is we take a very complex system that we already have and make it even more complicated. And I would be more in favor of trying to make this simple.

I also think that making it simple maybe asks us to be a little bit up front about what we're really trying to do because I think it makes the options more simple. If the action here is to say that our goal here is to pay certain specialties or certain service givers more, then we just need to be real up front about that. And finding back door ways to do it through manipulating RVUs I think is really not in anybody's best interest. It just relates to creating more hostility and resentment, I think, for the dishonesty really that it represents.

And so I think that if we want to say we're going to define a body of services for which we wish to provide payment in a nontraditional way that's not face-to-face, that's not subject to the RBRVS or any other constraints, I think that's fine. But I think that's what we need to say it is that we're trying to produce here and do our very best to define what that is and measurement what that is and reward quality and doing it.

I think the interdigitation with Part D, I would

support Nancy very much, because obviously advice about drugs and their appropriate use. In some cases, trying to make drugs go away. I think what I hear from geriatricians is that oftentimes the very biggest benefit they can offer is stopping all the drugs and starting over. So I think to leave the drugs out of it is probably not a very good idea.

And then the last thought I would leave is that I keep hearing cognition and procedures. I'd like to remind you there are some other pieces to the system here. And that relates to tests and imaging, and maybe some other things other than major procedures. And that E&M and major procedures both have experienced relatively smaller growths, and that one of the goals may be to set out a medical or coordination of care or primary care or whatever it is we're going to get ready to pay for here is making sure that we're paying only for the appropriate services and tests. In some case that may mean increase in volume of certain tests that are good in chronic disease management.

But for every patient with a thyroid nodule that comes to me with sono, a thyroid scan, and either a CT or an MRI, clearly is a place where savings could be made and it rests in the hands of the owner of that patient initially.

Those would be just some thoughts to throw out.

MR. EBELER: Quickly, I think in part what we're trying to do is narrow the scope of future staff work. But if you start with page six, I would agree with the general consensus that we're talking about column three. Columns one and two aren't what we're talking about here.

If you go to page eight in terms of targeting, I don't know what to pick here. My impression is a chronic care medical home is a very different thing than a primary care case management medical home. It just strikes me as you're asking it to do -- it would be useful to me just to have a straw man, what is a complex chronic care medical look like? And what is a primary care medical home for the average non-chronically ill person? Because if we have to pick, we've got to pick. But it strikes me as two different animals.

On page 10, I'd agree with Karen. It's terrific that the professions are doing this. It doesn't strike me as something that Medicare payment will help, and might kill. It comes out for purposes of this discussion.

On page 12 on the fee schedule stuff, in some ways to me this looks like a phasing schedule. I know the fee

adjustments are blunt. Evaluation and management is blunt. On the pie chart, only two-thirds gets to primary care physicians, if you read it aggressively. But my guess is it's a pretty good portion, to get to Bob's point earlier, of that primary care physician's income.

So it may well be that's something you start with. I'd worry that we missed an opportunity to follow up on Nancy's recommendation this morning.

Then you move to these longer-term policy changes where you are in effect trying to get that. So it strikes me that you start with one and then move to two possibly, as a way to think about this.

MR. HACKBARTH: Okay, thank you. Good work.

We'll now have a brief public comment period. The same ground rules as this morning, no more than a couple of minutes and identify yourself again.

MR. SHAW: John Shaw from Next Wave.

Just something brief, trying to get hands around the bundled payment around the hospitalization. I had a hard time conceptualizing, as well. Maybe it's not impossible but difficult.

What makes it easier is trying to take a patient,

Alice, and conceptualize here into maybe three families of glide paths. The first that was presented looks like an acute glide path and might be a good fit for AMI or pneumonia. There may be another glide path where looking across the time frame, you may want to look out prior to admission for avoidable hospitalizations, looking out however long is appropriate for that particular avoidable hospitalization. And then the third family might be those that have an extended recovery that we talked about a lot during the day, post-acute care and things like that.

The glide path for the extended recovery, I'm not sure step two and three apply to. That just looking at the hospital and doctor, without looking at post-acute care, probably may not be meaningful.

The other thing that would be necessary in that glide path is to have a uniform assessment tool across all the different silos that fit in that category.

The last thing with all of them, step one may be the most important of all the steps. Because if you get the transparent view of the entire stay for a particular condition and make that available, I think you will get a lot of ideas coming out from that, just that alone.

MR. HACKBARTH: Okay. Thank you, and we will convene at nine o'clock tomorrow.

[Whereupon, at 5:42 p.m., the meeting was recessed to reconvene at 9:00 a.m. on Friday, January 11 2008.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 11, 2008
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, J.D., Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI, J.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
KAREN R. BORMAN, M.D.
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE, J.D.
DAVID F. DURENBERGER, J.D.
JACK M. EBELER, M.P.A.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, PH.D.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody.

We are going to depart briefly from the published agenda and quickly go back to our discussion and recommendation on special needs plans that we voted on at the last meeting.

Jennifer, you will take it from here and explain what's going on?

MS. PODULKA: No problem. This is just a brief correction on one of our list of seven recommendations -- let me just go ahead and put this up.

This is the draft recommendation six, that the Congress should basically change dual eligible beneficiaries' enrollment opportunities. If you remember from December's meeting, what I said was that dual eligibles are able to change plans on a monthly basis. The commissioners were concerned that this was one factor that contributes to marketing abuses to dual eligibles.

Bill, at that time, I believe you asked a question about special enrollment opportunities for institutionalized beneficiaries. I erred in my answer to your question.

Dual eligibles and institutionalized beneficiaries

enjoy the same enrollment opportunities. So right now what we're going to discuss is a very limited wording change, and that's extending this draft recommendation to both dual eligibles and beneficiaries who are institutionalized.

DR. MILLER: Italicized word.

DR. HAYES: Right, so the only change to the wording in the bold-faced recommendation is on the screen in the bold-faced word. The Congress should eliminate dual eligible -- and this is the change -- "and institutionalized" -- the rest of the same -- beneficiaries' ability to enroll in Medicare Advantage plans, except special needs plans with state contracts, outside of open enrollment. They should also be able to continue to disenroll and return to fee-for-service at any time during the year.

MR. HACKBARTH: Okay, so we need to vote on that amended language.

All opposed to the new language? All in favor? Abstentions?

Thank you, Jennifer.

Now we'll go back to the published agenda, the first item on which is delivery system reform.

MR. GLASS: Good morning. I don't think we'll be quite that fast on this one.

We're thinking of a chapter in the June report with ideas for improving program sustainability through payment and delivery system reform. At our November meeting you asked us to include our policymaking framework as part of the chapter. We'll briefly review this framework today as well as a possible direction for delivery system reform that follows from it. This should help put in context the discussion of medical homes and bundling that you had yesterday.

The motivation for the Commission to talk about payment and delivery system reform is the current status of the Medicare program. Medical technology has advanced, life expectancy has increased, and the Medicare program has fulfilled its basic mission of providing the elderly and disabled access to medical care. However, in spite of, or maybe because of, that success the Medicare program is projected to be fiscally unsustainable over the long-term. We must increase the value of what the program is buying to increase quality and reduce cost growth. Even if that's done, sustainability could still be a problem and other

changes to Medicare financing or benefits might still be necessary but they are not the subject of today's briefing.

The Medicare program is unsustainable over the long term because of the size of the projected financial shortfalls. The Congressional Budget Office estimates that Federal spending on Medicare and Medicaid will rise from 4 percent of GDP today to 12 percent in 2060. CBO also points out that most of the increase is from higher costs per beneficiaries, not an increase in the number of beneficiaries. It is the growth rate of spending. Moreover, the incentives that are inherent in the current payment system will continue to drive rapid growth if unchanged. The fee-for-service system will always reward increases in volume.

Now if more were always better, there might be an argument for trading off other social goods for more health care spending. But the evidence is that more is not necessarily better. Looking at differences in spending across geographic areas shows that higher spending is not associated with better outcomes or higher quality. In fact, there's often an inverse correlation, more is worse. Or to put it another way, value for the dollar is lacking.

Others, such as IOM, have determined that small changes at the margin are not going to change the direction of cost growth. Fundamental changes are needed in the payment system to help catalyze the fundamental delivery system changes that are needed to increase value. So let's look at what we mean by increasing value.

As the first part of our policy framework, we have defined four determinants of the program's value. The first of these is access to care. Beneficiaries need to be able to obtain care, and the care that is delivered should be appropriate for their clinical needs. For example, they have access to primary care and not just the emergency room.

Second, quality of care. Care should be safe, effective, patient-centered, and timely.

Third, efficient use of resources. Efficiency, that is producing a given quality outcome with the least resource input. This influences the cost and sustainability of the program and makes the best use of the taxpayer's dollars.

And finally, equity. This is fairness among providers and beneficiaries and it is a judgment. It's subjective. But it encompasses issues such as beneficiary

out-of-pocket costs, adequacy, and comparability of provider payments.

Some of these concepts overlap. For example, beneficiaries cannot have high quality care if they do not have any access to care. Access and equity are also interrelated.

Just for clarification, although some of the concepts may be applicable inside the Medicare Advantage program, as well, this presentation concentrates on increasing value in the fee-for-service program. The pressing issues with the MA program have a different focus and we have discussed them elsewhere so we'll not do so today.

To help judge whether policy proposals will help increase value, we analyzed some of the problems in the current Medicare fee-for-service program such as lack of accountability and care coordination, lack of usable information, inaccurate prices, and poorly targeted technology diffusion, and arrived at the following principles for improving value. These principles are the second part of our framework.

First, we would want any policy to promote

accountability and care coordination. Will providers be held accountable for the Medicare resources used by the beneficiaries they treat? Will the policy encourage providers to coordinate care with other providers and break down some of the barriers that current payment systems may create?

Second, we need to create better information and tools to use it. So we would ask will the policy encourage the collection and dissemination of clinical resource information, and tools to make collection dissemination and analysis of the information easier, and not place an undue burden on CMS, providers, and beneficiaries?.

We also want to improve incentives. We want to encourage higher efficiency -- both lower-cost production and higher quality -- rather than increases in volume.

In addition we would ask does the policy address the problem that it's intended to solve efficiently? For example, does an intervention focus on the provider or beneficiaries for which it creates the most value?

And finally, we want to set accurate prices. Will the policy send the correct signals to the providers, beneficiaries, and purchasers and avoid unduly favoring some

services and beneficiaries with certain characteristics over others?

If these principles were put into practice, it would be a major step for Medicare. But to get maximum value, policies should also promote alignment with the private sector. Coordinating programs in the public sector with those in the private sector would provide greater leverage on providers and at the same time decrease the administrative burden on providers. For example, using the same measures in public and private P4P programs would greatly simplify and reduce the cost of gathering data.

With this as our analytic framework, we now turn to realizing value through payment and delivery system reform.

This is the big picture for outlining a long-term direction for payment and delivery system reform and it puts into practice our principles for improving value. Glenn, we didn't have enough room for the fourth column that you mentioned yesterday with the ultimate solution at the other end. We'll work on that.

We are now in the first column, under current fee-for-service payment systems. The basic problem with all

fee-for-service systems is that they reward increasing volume, although to varying degrees. In general, if you do more you get paid more. Also, because they're distinct and separate, there's a problem of coordinating across payment systems.

The Commission has recommended using the tools in the middle column to try to increase value in the fee-for-service system consistent with the policy framework we've just discussed: a comparative effectiveness entity to give providers and payers information on what works best; pay for performance programs within existing fee-for-service payment systems to reward quality providers; reporting resource use to inform physicians of the consequences of their practice patterns and how they rank relative to their peers; bundling individual services within a payment system to encourage efficiency within the bundle as recommended for outpatient dialysis; and creating pressure through updates to limit cost growth, as you discussed yesterday in the hospital system.

However, there are two major limitations to these tools. First, marginal rewards may not be sufficient to overcome the incentives for more volume. A small quality

bonus won't drive someone who is seeing five patients an hour to seeing only three. Second, working within individual systems inhibits changes in the delivery system that either cross borders or extend over time. For example, as Dr. Kaplan from Virginia Mason discussed with the Commission some time ago, physical therapy may be less costly, more effective, and provide greater patient satisfaction than an MRI for back pain but there's no reward for doing that substitution now.

So we're exploring three approaches for overcoming these limitations. They pay for care that spans provider types and time and they hold providers accountable for quality and resource use.

You discussed the first two concepts, medical home and bundling, yesterday. The medical home, I won't go through those discussions but it's interesting that the medical home discussion you had yesterday links in with the determinants of value we've discussed in this briefing, the 24/7 access that Karen talked about as being a feature of the medical home, for instance, would increase access. Several people thought it would increase quality. It would certainly increase equity between primary care and the

specialist providers.

You also discussed bundling, and that's either a good theory for the things we've shown up here or perhaps impossible, as was discussed yesterday.

But the third concept is accountable care organizations. This is a broader concept. It would be a group of physicians, and possibly a hospital as well, that would take responsibility for a population of patients for a broad set of services over some period of time or episode. They would be held accountable for performance on quality and resource use for that population and have an incentive to control volume. Payment could be fee-for-service with some add-on or possibly some form of capitation or virtual. This would present many difficult issues of its own, which we will discuss if you want us to develop that issue.

The goal of all of these approaches is increasing value for the Medicare program, its beneficiaries, and the taxpayers. That means is creating payment system incentives for providers that reward value and encourage closer provider integration, which in turn would make use of tools such as P4P even more beneficial. Each of these proposals will require careful consideration of unintended

consequences and will present many thorny issues to be resolved, including the following fundamental questions.

Should incentives be based on individual physician performance, physician group performance, or the joint performance of physicians and hospitals? It may be desirable for groups of physicians and hospitals to be jointly responsible for a common set of process and outcome measures. If they share responsibility for each measure, their incentives would be aligned to work together to improve performance. However, some providers may be reluctant to be held responsible for outcomes that are not completely in their control, and making a group rather than an individual the locus of responsibility may dilute the magnitude of individuals' financial incentives to improve their performance.

The second question is what responsibilities do beneficiaries have? Should cost-sharing be designed to motivate patients to use certain providers? To what degree should patients be locked into seeking care from the set of providers once they pick their provider? These were raised in the medical home discussion yesterday.

Should we wait for payment policy proposals to be

fully demonstrated and evaluated, or should we move more rapidly? Even if payment reforms were adopted relatively quickly, we may need to wait another five or 10 years to see improvements in the value of care delivered. It is difficult to determine how long we should spend gathering additional information while delaying changes in the current health care system. Some observers may be reluctant to risk harming the system with rapid untested changes. Others, who feel the current system is performing poorly, may be more willing to take risks to speed health care system reform.

Another question is are changing the financial incentives enough or will additional steps be needed? For example, several commissioners have suggested that graduate medical education needs to change. Others have suggested that restrictions on physician self-referral may need to be tightened.

And finally, does there need to be a penalty if providers do not participate? Providers attaining high-quality, improving quality, and restraining resource use should receive above average Medicare payments. However, to induce physicians to be active in new incentive systems, does there need to be a substantial penalty for those who do

not actively participate? Should the existing SGR or something similar to it be used to constrain payment to non-participants to induce participation?

I leave these questions for your discussion. Thank you.

MR. HACKBARTH: Okay, thank you, David. Well done.

Let me offer a few thoughts to get us started.

First of all, this is for the June report. I can't remember if you mentioned that in your presentation. It's not for the March report. We've got some time to work on this and refine it to get it ready for June.

A second comment, as I see this chapter it's a directional statement. What we're trying to do is capture the Commissioners' thoughts about the general direction that policy needs to those over a fairly long period of time. That was the spirit that we discussed at the summer meeting.

With that in mind, I think the shorter, the tighter the statement we can make the better, the more useful it is. I have some thoughts, David, about where we might take out some material in order to highlight the really major points about the direction that we want to go.

In that same vein, I think we need to think carefully about how much detail and how much specificity we want to use in our examples, medical home, et cetera. Because concurrently, on a separate track, we're sort of looking at those as potential policy options for bold-face recommendations. We may decide to do them and embrace them in that discussion or we may decide to modify them. So we need to think about how -- obviously, we want to give some examples to give some meat to this directional statement but we have to be careful that we don't go too far.

One last thought is in terms of the directions we want to go, I think an important theme worth underlining a little more prominently is the synchronization idea. You mentioned it here in your presentation and it's in the paper, as I recall. At least to my way of thinking, that's sort of a major idea. And by synchronization here, I'm referring to trying to get the signals sent by public and private players more clearly outlined. There are multiple components on that. We should be using common measures, potentially using common datasets so we give consistent feedback to providers, maybe even be setting common clinical goals so that we can focus people on Nick's low-hanging

fruit. I know there's lots of issues to be discussed in there but that's my perspective.

So there are a few thoughts that I have.

MR. DURENBERGER: Thank you. I agree with everything that you've said and I really love the way the paper is shaping up. My comments are intended largely for context.

When I present on this subject, I usually start with a picture used in my 1982 campaign of me in my shirt sleeves like this, my arms crossed, holding a pipe in my hand, looking endearingly at whoever's looking at the picture. And I say that picture was taken when I was chairing the Health Subcommittee in the Senate Finance Committee, the guy with the pipe. Then I will laughingly say to younger audiences that had tobacco in it, not the kind of pipe you guys got raised on, that sort of thing.

And then I will mention, because he is deceased and wouldn't mind my saying it, that my predecessor as Chairman of the Health Committee, Herman Talmadge, sat there and smoked a cigar.

But the tagline on it is if I had known then what I know now, and then the rest of the comments.

What I did know in the early 1980s, because of experiences that we had had in Minnesota prior to that, my own personal experiences before I was elected to the Senate involved building what is now Buyers Health Care Action Group. They were no buyers in the system so how could you buy intelligently? And so we built that capacity.

So what I did know as we began this change of the health policy from reasonable and customary charges of Medicare into something else, I did know the value of real competition. I did know the value of informed consumer choice. I knew the importance of aligning incentives and of informing those choices. Part of that was instinctive maybe, but the larger part was all the work that had proceeded getting into the Senate.

What was good about that period in the 1980s, and particularly looking at the Senate side, was there were a lot of people just like me, starting with Russell Long and Bob Dole and Bob Packwood, and I can mention plenty of others.

The two of us, probably, that felt the most strongly about changing the direction that we're talking about doing here from this volume-based bill paying service

were John Heinz and I. And I think both of us had had experiences, he in Pennsylvania and I in Minnesota, with the importance of doing that.

So prior to 1982 we were experimenting -- despite objections from John Cogan, who was then at OMB -- we were experimenting with HMO cost-based choices. Obviously we thought they worked pretty well. But it was kind of hard to prove that because somebody would say yes, that's Minnesota or that's Seattle or Portland or wherever it was, one of those kind of deals.

My point is that in a contextual sense from the time that we did the TEFRA risk amendments -- John Heinz put that on the budget bill in 1982 and then we did prospective payment in 1983 -- we intended a two-track course to finding ways to build accountability through the payment system. They both emerged about 1985. But the earlier track, the 1982 track, was basically to privatize the Medicare program eventually by using the then-existing HMO-like organizations, paying them 95 percent of the fee-for-service dollar and seeing what they could do with it. And the other track was prospective payment for everybody.

When I reflect on what we did at that period of

time, I say I wish I'd been smart enough to say let's keep the risk contract HMO thing going in the communities in which it was working. We went, for example, in the Upper Midwest we were that top quartile -- including Nick and North Dakota and places like that -- of spending AAPCC. And in two or three years we went to the bottom quartile. And was all because doctors changed their behavior working with local health plans in one way the other.

So let the rest of the country do the prospective penalty thing or opportunity thing and the rest of us will do the competition among the health plans, the competition between providers, and all that sort of thing.

I'm not going to go through the evolution of that except to make the argument that as we present this paper and a clear, succinct, straightforward way, and as you urge us to think about synchronization, I really think it's important, particularly for the policymakers -- all of whom are new and their staffs are all new to this sort of thing -- not to think that somehow Medicare Advantage started in 2003. It had a 20-year or more lead time. This is not new. It's not that it hasn't been tried.

And I'm refortified in thinking about this by this

little thing Arnie said yesterday, which is what's our Toyota. There's one here on my left that's an American Toyota. And we have other examples around the country.

But from a policy standpoint it just seems to make sense to set up all of this work that we suggest doing in delivery systems with the particular accent on accountability and that sort of thing, to set that up with that kind of a context.

And so I would hope that we can figure out how to do that.

MR. HACKBARTH: Yes. In a nutshell we're talking about one of those two tracks, the non-private plan track, and how to build in accountability to that track and to bridge the silos, et cetera. Those are of the themes we want to be prominent.

Where did he go? I was going to move John up in the queue because I know he has to leave. I already missed my opportunity.

DR. CROSSON: Thank you. I have a feeling I should be delivered these remarks in Japanese but I don't have that facility, so you're going to have to bear with me.

Thank you for the report. I think this is heading

in the direction that a number of us had hoped it would head and I'm really looking forward to the June report.

I have a few points that are both small and large. First, a small one. The issue of the values and the point about equity I think is a good one. I was a little bit concerned that it overstated the subjectivity.

Now this is a strange thing to say in January after working our way through the updates that we just did. But actually, I think that to say that equity is inherently subjective is a little bit of an overstatement because, in fact, a lot of the work that we do here at the Commission, when you think about it, in the updates and some other areas is an attempt to objectify the issue of equity through the analysis that we do and we present. And I think it understates a bit our mission to say that it's just inherently subjective.

On the issue of the question that was raised about performance at the institutional or at the individual physician or individual provider level, it's a complex answer. I think the simple answer is that the right place is both, for two reasons. First of all, performance at the institutional level solves a number of problems in

performance reporting. It solves some of the mathematical problems in trying to develop a large enough N to produce statistical significance for comparison purposes. And by doing so, increases the number of things like can be measured accurately.

It also solves, to a large degree, the problem of attribution. That is if you have a bad result, or a good result for that matter, whose responsibility is that? In some cases it's easy to attribute that to an individual but in many cases -- particularly as care becomes more complex -- it is not.

There are some issues that are attributable to individual physicians. I think the direct level of satisfaction of a patient with their care is often one of those things.

Another reason is -- and I think here there is a natural tension that's present in this field, and I think it was well played out recently -- I think it was last week -- by Arnie in his article in the New England Journal. There's a bit of a natural tension between the desire of organized systems to manage individual performance internally and to battle resistance against measurement by some levels of

confidentiality, at least for some period of time, versus the desire of the public if you will to have information available about individual performance. There's no easy answer to that. I think a balance needs to be created at some point.

And finally, I'd just like to make a couple of comments that are similar to the ones I made yesterday, and it has to do with the medical home and the bundling issue.

I have this notion that as we play these issues out, if we take them beyond relatively simple concepts, that they walk their way in the end back to the accountable care organization notion. I think the medical home -- I said this yesterday and I'll just repeat it briefly -- if you go beyond the initial definition as a medical home as a couple of doctors and their staff coordinating care armed with a bit of technology, and you begin to take that further into the area of using this for payment, particularly the acquisition of risk, then you begin to push it towards the kinds of structures that I think we're going to identify as accountable care organizations. You simply can't do that at that small of a delivery system level.

I think to the same degree a bit the bundling does

that. We talked a little bit about it yesterday. As we play the bundling idea out and begin to then deal with how to get physicians and hospitals to work together to deal with the payment, who controls the payment, how is it divided, how are decisions made about whether to enter bundling or not enter bundling, issues of structure and governance, there's a great likelihood that if the bundling is successful that it will eventually lead to the creation of structures. This is not a bad thing but it will eventually lead to the creation of different structures that, then properly incented, take us towards the accountable care organization idea.

We might think about how we want to structure these. Or are they in fact discrete? Or is there some sort of a natural dynamic that we could consider among them?

MR. HACKBARTH: Potential building blocks towards something different.

MS. BEHROOZI: Thanks. At the risk of sounding like I might be contradicting a principle that Glenn laid out, I actually really liked the comprehensiveness of bringing everything together in one place. Maybe there's just something that I need and it's very helpful for me.

But on that theme, there's actually something that would be -- I think it would be valuable to add in connection with some of the other concepts.

Even in my short time here I guess a few times I've talked about the concern about costs presenting a barrier to access for beneficiaries to appropriate care. Not an appropriate barrier to inappropriate care, but an inappropriate barrier. And sometimes the response has been well, that's what we have the low-income subsidy programs for -- I know that's the name in Medicare Part D -- but programs for people who meet certain income thresholds that are unrealistically low. Whatever else you think about Mike Bloomberg, at least he's talking about the notion that maybe the Federal poverty level is not necessarily a realistic way to judge whether people can afford what it costs to live in this society, particularly when it comes in this case to medical care.

So I think it's important to think about beneficiaries not only as poor or everybody else but in various strata of being able to afford or wanting to be able to conserve their resources -- we're talking largely about people on fixed incomes -- wanting to be able to conserve

their resources to pay for other things, like the prices that are going up because of the skyrocketing cost of fuel or whatever.

And we see that people behave consistently with wanting to save money by joining Medicare Advantage plans. Again, here the terminology is often "for the extra benefits." But in my experience, whether it's with my family or the retirees that we cover or whatever, it's because they want to save the money. And so they're willing to forgo a certain amount of choice. They are willing to join a plan in order to, as I said, conserve their resources to use it somewhere else and not spend it all on medical care. And that is not producing any value to Medicare, that choice that they're making, based on the lowering of costs.

And we've had a presentation here on value-based benefit design. And I think the concept is kind of woven in when we asked yesterday, in the presentation on medical homes, should beneficiaries be incented to join up with a medical home by having their Part B premium reduced?

I think it would be helpful to reflect some of that kind of concept in the paper about -- there's acknowledgment that beneficiaries will make better choices

based on information about higher quality providers. But I think we also have to recognize that they are already responding to economic incentives. And it's not so much the stick but the carrot of lowering costs. And like I said, I think that kind of merges very naturally into this concept of value-based benefit design. Because no matter how accurate the pricing is, as you point out in the paper, the structural flaw of the fee-for-service system is that whether it's too low a price or too high a price -- and I presume that means also if it's the right price -- there's still the inherent motivation to increase volume.

So that's an additional thing that I'd like to see in there. Sorry, Glenn.

DR. SCANLON: I wanted to relate this to a couple of themes that we had yesterday. One was the issue of how long it's going to take for all of these things to happen. And from that perspective, I think that it's important on your slide seven to recognize that we're going to live in this current fee-for-service payment world for a while.

The second theme from yesterday is this issue of can't we improve upon this process of updating? And I would say can't we improve upon the process of the base rates for

the fee-for-service program as well without some of the kinds of changes that we're talking about?

We talk about the update in terms of being a blunt tool for efficiency. I think one of the ways that we might get people to start to focus on doing things more sophisticated is to stop talking about how we are driving efficiency. We're driving, through our systems, incentives for lower costs. Sometimes they might be coming from efficiency gains. Other times they're coming from lower costs, which involves changing the product.

There are companies that can produce cars cheaper than Toyota. Does that make them more efficient than Toyota? Or are they producing something different? I think we forget that when we talk about health care when we say okay, we've done a bypass and that all bypasses are the same. It's not true in terms of the care that's going on in the hospital. A hospital, when it's facing high cost and is overpaying its executives and is under pressure, can decide we're going to cut staff, we're going to cut supplies in ways that really do have an effect on the patients. We don't capture any of that.

And I think that we need to consider in our

discussion starting this summer in terms of revising the update, also think about do we need to make more differentiation in terms of defining the product so that we are getting more value for the dollars under the current system without something that is labeled pay for performance but within the current system.

DR. MILSTEIN: First of all, as a Commissioner, I feel there are these periods where we go into phases of diversions where all the comments seem to take a recommendation and pull it in a million recommendations, and them moments of convergence. I'm sensing the latter this morning. It's a good feeling after yesterday, my first comment.

DR. MILLER: [Inaudible.]

[Laughter.]

DR. MILSTEIN: The second comment is that in the spirit of that, on the list of recommended tools one of the things that we discussed yesterday -- and as I looked at the recommended tools it seemed to me an important one for our consideration that I didn't see listed -- is CMS/provider gain sharing relative to the providers' own individualized starting point. I don't think that any of the tool

descriptions fit that. I think it's exemplified by most of the Medicare demos where the individual just takes whatever the baseline is, improve upon it, and then share with the government a percentage of the savings.

MR. HACKBARTH: Just a question on that. The way I read the recommended tools list, these are past MedPAC recommendations. And then the potential system changes was where we might go from here. Did I interpret that correctly?

MR. GLASS: Yes.

MR. HACKBARTH: So your idea would go in the third box.

MR. GLASS: Right.

DR. MILSTEIN: Thanks for that clarification.

DR. MILLER: Can I just also say something, because in some of the e-mail exchange that we've had, and in some of your comments -- and I want to crystallize this for people. Because a point in your thinking has only recently become clear. Some of it was the e-mail exchange over article and that type of thing.

I just want to make sure this is correct and then that everybody's following. You're talking about a standard

here where whatever the efficiency incentive that's put in place is peculiar to the given provider or group or entity that is defined by it. And then it's efficiency off where they're starting from and accumulating it over time and then saying if I have established a baseline and you come in below that, you can share in some of the savings.

And why I wanted to just draw that out is because I think sometimes we talk -- there are conversations that are well, we're going to have efficiency standard which may not be peculiar to the specific provider.

And what Arnie is saying -- and it's only recently -- and I apologize for this -- that it became clear in my mind what you're talking about. You have a different idea in mind. And I think we've had exchanges here where we've all been saying the efficiency, standard, benchmark. And I think sometimes it's been different in people's minds. And it only recently became clear to me that that was going on.

DR. MILSTEIN: Thanks, Mark. Thanks for articulating that. Because my intuition is that a situation in which everybody has a chance to win is better than one in which you start out with half the people winning and half

the people losing.

MR. HACKBARTH: Just one further question on that, Arnie, just so I understand your idea. The first problem that comes to my mind in thinking about that is that the Toyotas, the existing Toyotas, start from a low base. So would you address --

DR. MILSTEIN: I tried to clarify that yesterday in saying I think that any provider that meets our standard for excellence -- Toyota or whatever it may be -- and yesterday I speculated it might be providers that score nationally in the top quintile on both aggregate quality and aggregate efficiency. For those providers we may want to make a supplementary payment so they're not held to the standard of improvement if they're already at the very top.

MR. HACKBARTH: Different pool.

DR. MILSTEIN: Yes, for a small slice of those that we think are really -- represent the benchmark nationally.

So, anyway, that's a comment or two. And thanks for the clarification about the columns.

The third comment I want to make -- and this is really a question for everybody because I don't really know

the answer. It came out actually, and I remember very distinctly, in Bob's questioning of Virginia Mason, Gary Kaplan. That is when I sometimes talk about this idea of any of these payment reforms, because at the end of the day -- in the end what you're trying to do is to take out of American spending whatever fraction is associated with no gain in health.

The challenge for us, it seems to me today, is that number, according to many observers, is large. Gary Kaplan's estimate was 50 percent. Peter Orszag's recent compilation of expert opinion was 35 percent. The IOM estimate in their systems engineering report was 30 to 40 percent. It's a huge fraction.

I wonder if we should maybe at some point be more explicit in our consideration of whether and the degree to which we want to think about some kind of -- I know it's a crazy term -- but reparation payments. We've got an American industry that grew and is supplying a large amount of services. There are a lot of mortgages being paid by people who are delivering on the old model.

And in retrospect we sort of say shame on us for creating these incentives. But 35 percent of those

mortgages are based on services -- if I can stretch the metaphor a little bit -- that are of no value or of value but are being produced very inefficiently and could be produced a lot less inefficiently.

So what is our theory by which we remove that 35 percent? And when I talk to hospital executives they get this right away and they go -- or health systems representatives. They say what's the deal? Are you telling me you're going to reduce my revenue? Are you going to offset that with improved margins? They're wanting to know what the nature of the deal is.

And I think that if we just go after value improvement and pretend like the industry is going to accept a solution that takes away 35 percent of their mortgage payments, it's unrealistic. Maybe we should think more explicitly about what we're going to do about that 35 percent waste and all of the American income, livelihoods, and future college educations that depend on that 35 percent continuing to flow.

My last comment, this is more of a reinforcement of what I said yesterday, anything we can do to adhere to the principles of so-called complex adaptive systems -- what

we're trying to do is we want quality increase in all of its dimensions while removing whatever percentage of waste is currently occurring, which is a lot. I'm no expert on complex adaptive systems theory, but what I have been able to pull from it is that what you want to aim for is the smallest number of changes likely to create the biggest forward movement.

And sometimes when I reflect back on our list of things, it seems to me that we don't fulfill that. When somebody says to me what did MedPAC recommend last year, oh boy, I have to go back and reread it. And even then I would be challenged to say what is the essence of it.

And I think that's one of the beauties of this chapter is it will, as Mitra said, will enable me to say really what we're after your is X, and X is something along the lines of what Jay described which is the creation of accountable care organizations, the scale of which is TBD, and creating an opportunity for provider gain through improved performance in both quality and efficiency.

It's that last point about anything we can do directionally to be able to answer in one or two sentences what it is we have in mind, I think, would be welcome among

many parties, including myself.

DR. MILLER: I'm sorry to keep responding so much or asking questions. I think there's some very fundamental things that we're discussing here, fundamental things that I've seen in our processes that I'm trying to draw out by this very conversation and by the questions we put up there.

Just to your final comments, which I understand, particularly the one about multiple versus single. Sometimes I think the thing you have to think about is if you go for one big bang, you've arrayed so much resistance to that that you can't get it, as opposed to a series of small things where you take on things one at a time.

You said I don't know the answer to this, and I don't think there is an answer to this. But I think we should think from time to time sometimes you want to -- and certainly at a principle level, it's really easy to say what principles you are pursuing. And everybody agrees to the words. But then it's the policies that actually have to execute the principle. And I think sometimes we have to think about is it a single or a couple of big things or small things? And I think different answers are right at different times.

And then there was one other thing that you said that I just want to tease out. You said the 35 percent, when you go to provider systems, people say so what's the deal? But implicit in that statement is leaving some of that out there for them, I think, unless you meant something else. Because that's the only way a system is going to say I'm going to enter into a deal is if I get to keep some of this.

So it's sort of we can't get it all. So I'm taking your comment as we can't get it all, let's figure out what the flex point is to bring people to the table.

DR. MILSTEIN: That's exactly right. That's why I was referencing Bob's comment to Virginia Mason because I think at one point Virginia Mason said now that we know how to take all this waste out, we're very happy to be capitated at current rates. And Bob's comment was that just allows you to internalize all the efficiency capture and implicitly saying, from Medicare's point of view, that's not going to work. We need some -- I would hope a majority -- of that 35 percent in the form of either less pressure on the Treasury or less pressure on lower income beneficiaries who are struggling to pay their Part B premiums.

DR. MILLER: I just wanted to make sure I understood.

DR. SCANLON: On that point, I guess, there's a question in terms of how you address it. In some respects there's a sense -- I get it very often -- that in health care everyone thinks they have tenure. These are lifetime appointments, we don't have to worry about it. And that's what you're talking about here. And I think popping that bubble would be potentially extremely valuable.

But then realistically it's not going to be possible to pop the bubble unless we do provide some sort of trade-off. There's a question of how you do it, whether you do it in the form of building some inefficiencies in forever or whether you take sort of like the trade adjustment assistance approach which is saying okay, the world has changed. We don't have any typewriter repairman anymore. And what we're going to do is we're going to compensate for that for the current generation, the current cohort. But we're not subsidizing training in that area for the future or create more people that are going to be unemployable.

And so I think we've got to think about a transitional strategy here instead of just building in a

bribe to say okay, go along with our efficiency gains.

DR. REISCHAUER: I just disagree with this as a problem. We're looking at this sort of like it's Michigan and the auto industry and we're going to have a shrinkage of activity. We are in a sector which has been growing extremely rapidly. Employment has been growing faster than any other sector and we're building hospitals left and right -- maybe not increases in beds but fancier stuff. There's all this discussion of will we have the manpower, will we have the capital needed to produce the health care that Americans, as they age, are going to need?

And so I don't see this as -- using Virginia Mason, but you can't internalize within that silo this stuff. The problem that they aren't going to have as many resources devoted to them, they're going to provide services for the same amount of resources or 4 percent more rather than 50 percent more, to a greater number of people. And what we're really talking about is just slowing down the amount of resources that go into this sector while at the same time providing improved care to a greater number of people.

And so I don't think we need reparations. I don't

think we need trade adjustment assistance. We don't need any of that. What we need is a restructuring of the delivery system.

DR. SCANLON: We do disagree but it's a numbers issue, which is that if we realign the resources to a more optimal model for the future, there's a question of whether or not we would be below the current projections in terms of how many people we need for different things, and the current supply, too.

Because we are so far ahead of the rest of the world in terms of what we are spending, there a question of is there a slack there even when we take into account future demographics future technologies, et cetera. It's a numbers issue.

DR. REISCHAUER: I guess what I'm saying is this is going to take several decades to pull off. If 35 percent is the perfect number, we are going to be lucky to get 25 percent. And we're looking at a sector that's going to double over the next 20 years. I don't see that this is a big problem.

MR. HACKBARTH: Let's get some other people involved in the conversation here. Nick, did you have your

hand up?

DR. WOLTER: No.

MR. EBELER: Nick, who is involved in an organized delivery system and has expertise, but let the rest of us talk.

[Laughter.]

MR. EBELER: A couple of things. And I think the discussion reflects how hard this is.

There is an implicit assumption here, and I think Jay answered it looking at the question of individual group performances and the answer is both. We have to be careful that the assumption isn't there's a vector that we're headed toward where we know what the right delivery system looks like and all of American health care delivery needs to look that way in 20 years.

I didn't think any of us are saying that but I think you have to be careful of that presumption, with all respect to KP. And I'm a fan of KP, I've worked for them. I don't think KP describes themselves as Toyota, particularly on the efficiency side. I just think that you really need to think here about different delivery systems, reforms that are different forms of accountability in

different communities.

Second, I think it's important to think about the unit of analysis here. There is a possibility that a unit of analysis is the community. Does one think of Virginia Mason as the place we're heading for or KP is the place we're heading for? Or does one think of the Twin Cities, and all of the stuff that's going on there with a variety of financing and delivery? There's an analytic construct that I think we have to be careful of here.

The issue of synergy with the private sector, I think as MedPAC I think we have to look really carefully at our MA/Medicare fee-for-service presumed dichotomy because I think the assumption that MA is heading in this one way towards accountable care organizations and Medicare fee-for-service isn't, I think is flawed. And in fact, I'm as worried if not more worried about the evolution of MA in the current environment where it is becoming private sector fee-for-service that may well be purchasing health care in a more inefficient way than Medicare does.

So I would challenge us, I think, as we think about this to do something -- I think Nancy said this two or three meetings ago -- sort of backward map MA policy against

what we think we should be getting there and be really clear about that.

And in fact, as a leverage point, I would argue that may well be a way for demonstrations to proceed rapidly. I'm not a fan of demonstrations at all or waivers or any of those other things.

Proceeding with sort of backward mapping MA, as well as with things like medical homes and models like John talked about yesterday. It may well be places to actually start here in very good ways.

By backward mapping MA I mean things like getting the same data from fee-for-service that we get from MA and vice versa on both efficiency and resource use and quality so that you can do both quality and efficiency comparisons among those systems, probably changing payment structures.

But it just seems to me that -- my mental image is that we've really nailed down what we want to do in Medicare fee-for-service and MA private fee-for-service plans are 50 percent of the market and we no longer even have leverage over the very system we're talking about. So I would push pretty hard there.

Finally, I think in this aggregate costs question,

I think I lean to Bob's answer. You deal with that through rates of growth. To try to slow the rate of growth is how you try to strip out some of that money. You clearly need some gain sharing and whatever. But it strikes me that that is logically the way you do that.

MR. HACKBARTH: Jack, could I ask a question about your MA point, which I think I agree with your basic message.

I don't think that we're on a track with MA right now that's going to produce what we want in terms of value for the Medicare program and its beneficiaries. In my view, a big part of that problem is the price we're paying. The payment mechanism itself, an overall population-based payment, is I think a very good payment approach.

But if the price signal that we're sending to the market is oh, it's okay, we want to buy things that not only cost as much as this fragmented chaotic Medicare fee-for-service system, we're willing to pay 12 percent more, and in some places 40 percent more. That's the price signal that we're sending. And that causes MA plans to evolve in a certain direction, and exactly the wrong direction. Would you agree with that?

MR. EBELER: Partly. I think there's also a question, a word you used yesterday, of accountability. I think that we are not asking MA plans to do the things that we think should be done. Again I just think -- now, I don't know how you square the presumption about where we're heading to organized delivery with a fully capitated private fee-for-service plan.

You can't hold those two facts in your head simultaneously. At least I can't. If you're smarter than me, maybe you can. So I think there's a huge accountability piece. And I think the accountability comes with lots more rigorous data reporting on the MA side as well as on fee-for-service.

As well as I'm very skeptical about 100 percent capitation. Large employers don't do it with their health plans. And it's not totally clear to me why Medicare would. I think differential payment policy coupled with differential reporting policy can help drive towards some accountability there.

MS. HANSEN: Probably three different aspects. One is kind of a set point. Another thing is to kind of go through some of the fundamental questions. And the third

area I'll probably do is emphasize the responsibilities of the beneficiaries.

Using some of the metaphors of Jay saying he should be speaking Japanese, I think what I will speak about is the delivery system. So think of it as if I'm speaking Chinese with an American accent here. So what I would like to emphasize, since it is about the delivery system, I'd like to take the point that it may well be, in terms of not 1,000 flowers bloom but some. The experience that I have is at the real community level over a period of time, and whether a small entity, an accountable care organization, can be responsible.

I was just going back through some of the old numbers here as to what it took to caring for an N of say 250 when PACE programs first began, with a ballpark of $10 million. But what that entity does, the accountable care organization -- which also, a.k.a., has a medical home -- does take the full risk there. So that's the financing lever.

But the delivery lever is where -- I think I've brought up on different occasions -- there really is a culture change of practice.

And speaking to your point, Arnie, it's like do all parties win in this one? I think that the short answer is yes in that people come, even the physicians, they stay. And people are inspired to work and there's a fixed budget that goes on.

And going then to the tool sets that we use, at On Lok where I came from, since 1993 we've had an electronic medical record with all physicians on it. We have had individual and group performance. Physicians get their -- we used national benchmarks. And their ability to perform on preventive screens and tools of that nature to see what they do. They have a full open formulary. A formulary but they can prescribe without asking for permission. But there are pharmacy reviews about this.

Part D was included, Part B with the medical care and all, Part A we paid for the hospitalization. We also paid for the skilled nursing facility. So basically, yesterday's chart, it's the full end of the continuum, a full risk, all services, not only A, B and D, but it's also chronic care, Medicaid services tossed into the pot as well. But I won't go there. That includes, when we talk about dual eligible SNFs and should we would be doing care

coordination, that care coordination is there including dental care, for example, and things like this.

The beneficiaries, in the second point here. The beneficiaries and their families, caregivers, do have responsibilities. I'll go that, as I said, a little bit later. It turns out we were a demonstration. Jack, you were part of our world of demonstrations during that time. And demonstrations can't proceed rapidly. It took us 10 years to do that. Nancy-Ann was a part of HCFA at that time for us.

We were the financial incentives enough? It was full capitation, meaning it's fully there. But it was not enough just to have the financial incentives. It really was changing the pattern of behavior of delivery. It goes back to the care coordination, the teamwork. Perhaps using providers that may be less expensive to do a result.

But we ended up with a margin. And if there was a margin one, we had to save for our rainy day just like a private business of any kind. But the rest of it we redistributed amongst staff. So this is where all boats rise in this.

And then part of it is something that's a little

different that Mitra -- from the standpoint of lower paid workers. We would also do an equity readjustment that physicians would get a certain amount, professionals would. But the lower paid workers would get a disproportionately higher amount because of the relative percentage. If you give everybody 4 percent then 4 percent doesn't mean a whole lot as much when you're making $12 as when you're making $70 an hour.

So these are the kind of things, it's a culture change that happens. And one of the downsides is it can't grow rapidly because those kind of cultures don't change when you're talking about major levers.

But I just wanted to give a face to the fact that the accountable care organizations can actually be fairly small. And we have 14 physicians on staff, with the whole panoply of cardiologists and surgeons as panels.

It's doable but I'm not saying it's easy. But it's possible. But we had people who wanted to be there. We had beneficiaries and family members who knew -- talking about end-of-life issues -- that we talked about what their plans were really on so that when that crisis hit, which we knew would hit, we would be able to manage that with the

family. And the family members not going kabonkers, wanting everything for that last six months of life. The majority of them didn't. Some people did want it and that was within their right. And it was a voluntary program, so therefore people could exit.

So I just wanted to give a sense that a delivery system and a financial system go hand in hand. But the delivery system is not composed of widgets. It's composed of well oiled wheels that turned in an alignment that go forward.

That's the reason I brought up GME in the past, that I think that kind of culture change starts early and it starts in settings where people can really learn and get their behavior reinforced financially, as well as in terms of the reason they choose to work, which is something we never talk about at a policy level. But I just wanted to say that for my accented language that I offer you right now, it's one of the things that makes it work for a health system possibility to change.

And I'm delighted that at this point we're even testing it out in rural areas. I understand Nick is going to be testing one out in his site.

But hopefully, just to understand, delivery system changes incorporate them all, but if we tease them all out -- which I think you have to do to understand it's the money but it's the practice. And the practice is about the results of the beneficiaries. And they have responsibilities as well, to take their medications. They get eyeglasses and all, but if they lose two pair, they pay out of pocket. So there are responsibilities.

And then finally, the one thing is we haven't mentioned this about beneficiary decision making but the Foundation for Informed Medical Decision Making that is, I think, an offshoot from the Dartmouth Group but based in Boston, have shown through their research that when you let beneficiaries really know about procedures and decision making, people do not choose more necessarily. But part of it is the time you have to invest in having people both get information, absorb information, and then make that decision.

So I hope we look at that part about reducing costs because it doesn't mean, just because we have a lot of procedures, that people want it.

And then I'll just say one thing about the

litigation. I'm just frankly amazed, if not delighted to say, I was there for almost 25 years and we've never had a litigated issue in the organization.

So I think there are possibilities of working. But I think it really takes, for me, culture change with a big C.

Thank you.

MR. HACKBARTH: I can see Nick is still working on his comments, so we'll go to Nancy.

DR. KANE: I'm probably along the same lines as Jennie, just saying in terms of the principles for improving value we should maybe -- which I think are on five and six or at five, maybe six -- that we may need to add something a little more broad picture like go back and look for opportunities to tweak the environment in which the beneficiaries and providers operate. Jennie gave a great example of going after medical schools and medical education. But I think there's other places to tweak the environment as well where we might want to be involved or at least make comments.

One I've already mentioned before, which is looking at market structures and thinking about whether

there needs to be a little tweaking in the environment of market concentration. It also relates to working with the private sector. And we have made the point very clearly that less financial pressure from the private sector increases cost.

We should go back to that stream of thinking and think why is it that the private sector is doing less pressure? Often it relates to the market structure that they're finding themselves in.

I think there is a real need to think about whether we need to make recommendations to further investigate the wave of mergers and the lack of competitive environments that I think a lot of markets are now facing.

But the area that I think I haven't brought up lately anyway, that I'd like to remind us of, is I think there needs to be accountability not only for one's group of patients. But there needs to be something -- I would like to see it reflected in the payment system actually. For population health, even if it's shared, even if there's a way to say you're in a market where people have an excess amounts of obesity or hypertension out of control or whatever, and make that market -- even if it's not one locus

of control, but that their payment levels reflect the health of the market and changes in the health of that market that everybody has to deal with.

I'm working on a case right now where in California they're trying to expand health insurance. The number one cost containment -- at least the top -- one of the top cost containment vehicles that the governor is expressing anyway is going after obesity because he feels the diabetic costs, the cost of diabetes, the rising cost of diabetes, is going to overwhelm the state's economy is someone doesn't try to get at it.

Medicare kind of gets it at the end, the 65-year-old coming in with out-of-control blood sugars and hypertension and the poor eating habits. Is there any way we can start thinking about incentives for the private sector employers and insurers to deliver a healthy 65-year-old or somehow get back and think about where the real costs are.

Public health people know that the medical care system only affects what, 10 percent of health, something like that? And the bigger issues are really lifestyle and exercise, nutrition, controlling basic problems of

hypertension and cholesterol, et cetera.

Can we create some incentives, either for the private sector or at least when we do get 65-year-olds, for the beneficiary themselves? And I think that's related a little bit to the value-based purchasing. But those are more, in the sense, a copayment. What can we get people to do, and preferably earlier than 65, to try to stop people from arriving in the Medicare program with giant health problems that they live with much longer than they used to, 20 or 25 years of chronic problem.

What I'm saying is in terms of principles for improving value, we're looking at, I think, how do we get at the providers. But I think there's a lot of environmental pieces that we're really just churning around at the margin unless we start thinking about the bigger environmental pieces and what we could try to have an impact on, even just by talking about it and getting a conversation going.

The last piece is that all of our different models, accountable home, medical home, accountable health care -- I'm going to repeat the last time. We haven't thought about how does Part D get put in there? How do we get the accountability for Part D into the medical home or

the accountable health care organization?

Is the provider going to be able to work with the Part D plans of these different beneficiaries and get information on compliance and utilization? I think that's vital. I don't know how you can manage a hypertensive without knowing what drugs they're taking, or a congestive heart failure patient, without knowing what their drugs are.

So I guess the interaction between Part D and the rest of the fee-for-service system really has to be addressed directly. It just astounds me that we can't even, for public safety, get information from the Part D plans.

I'll stop there.

MR. HACKBARTH: Two quick thoughts, Nancy. On the Part D issue, as we discussed with the panel on value-based benefit design, the decision to separate the insurance risk for the drugs versus everything else has big ramifications for the integration that needs to occur in the real world, looked at from a delivery system standpoint.

Now it can happen in Medicare Advantage where a plan offers both the A and B coverage and Part D. But when you're talking about traditional Medicare, you've got separate insurance pots, you've introduced a major

distortion in the system.

DR. KANE: Especially if they're not telling the providers what they see in their claims database. I don't see how you can manage care without that information.

MR. HACKBARTH: I think you're absolutely right to flag it and we need to think what can be done in the face of this distortion that's been introduced. But it's a big barrier that's been put in place.

The second thing is I've been reflecting on your comment at the end of the day yesterday about the need to maybe communicate priorities.

I have this vague, vague, vague vision of a schematic. There are lots of important processes, for lack of a better term, that need to be influenced here. Ron has mentioned the education and training process. You mentioned population health. Jennie mentioned how patients make decisions. There is the primary care delivery process that we talked about yesterday. There's the inpatient process and the immediate post-acute that we talk about in bundling.

You can envision mapping some of the key processes and say here are what we think the most critical policy levers before these major processes. And you may not do it

all in one fell swoop, but when we talked about developing this chapter I think part of what we wanted to do was number one, communicate with the outside world about our priorities. But also set a framework through which we can evaluate our own work and say are we addressing these major processes? Have we established clear priorities that we think have real leverage? It gives us a tool to go back to and evaluate what we're doing and then use that evaluation for our future planning.

Does that make sense to you? Is that responsive to what you're getting at?

DR. KANE: Yes. There's little pieces, there's big pieces. I think we need a lot of pieces. I'm convinced about that.

But where are we going? How do we know we're getting there? Where are we trying to get to? And how do these pieces fit into that? And then it may help us also think about what level of effort to put into any one piece. I think it's much easier, in fact, to put a whole lot of effort into a tiny piece, the medical home, and then spend lots and lots and lots of time and miss a much more likely to have impact piece because we're down there in the -- so

it's nice to keep going up and in terms of the level of detail.

MR. HACKBARTH: So let's think if we can...

DR. STUART: Thank you. Coming at the end, most of what I had to say has already been said. But there's one thing that I think is really important to set the atmosphere for this chapter. It's actually built on something that Dave Durenberger gave us. I was really appreciative of your perspective on if we only knew then what we know now.

And this also has Minnesota roots, and it goes back a decade earlier to Paul Elwood and his coining of the term health maintenance organizations. There was a lot of excitement at that time in terms of what these organizations can do.

What's happened over time as that term is completely debased. Jay's organization and some of its cousins really go back to that origin. But most do not.

And my fear is that here we've come up with a new term, accountable care organizations. And if Paul Elwood were sitting here, he'd say what's the difference between an accountable care organization and a health maintenance organization? It's just language.

And I think the difference, however, today is that we've become a lot more cynical about this language. And I think we have to be very careful and should address this directly, that if people think that accountable care organizations are just some other acronym that is same old, same old -- which I fear they will -- then I'm not sure that we will have accomplished very much.

And so even though I agree in principle with what you say, Glenn, about having this thing at a high level and talking about principles, I think you have to bring it down to the level of saying there is something different here from what we've had before. And I think this really does belong just not here in his room but also belongs in the chapter.

Because language is a very, very powerful tool and it's very easy in this world to just simply disregard what somebody says because it sounds like a lot more of the same thing.

I've got two other things that are building upon what other people have said. The second bullet point here, creating better information and tools. And again this is building partly also on what Dave said. We do have this two

track of having coordinated care -- or we hope we have coordinated care -- and then trying to provide the right kinds of information and incentives for individual providers.

And frankly, the information expectations and needs are very different for individual providers than they are for coordinated care organizations. I mean, you can reasonably expect and hold large organizations accountable for having the information in order to provide the service and to be accountable. For individual practitioners, that's not the case. You have to have some mechanism by which they can be kept informed about the progress of their patients. That gets into Part D and some other things.

But we really don't talk in this chapter about what kinds of specific informational tools would be different in the private fee-for-service sector than they would be in the coordinated care sector.

And then thirdly, and this really does pick up on what Nancy said and what you said, Glenn, about Part D -- although I think it's broader than Part D. And that is not only do we want to have incentives to build coordinated care that meets accountable objectives, we also want to remove

artificial organizational impediments to care coordination and value purchasing. And that's terminology I'd like to see something like that in there.

Because the standalone part of Part D really does do that. There's just no way that individual medical home would be able to deal with a large standalone PDP and get the kind of information necessary to provide good care coordination.

But it's also the private fee-for-service plans in MA. It's probably three-quarters of the so-called coordinated care plans under MA. And so I think that if we think about this from a structural standpoint rather than simply from a provider standpoint, that there are organizational impediments that Medicare should work to reduce, if not eliminate.

MR. HACKBARTH: Bruce, I think your point about language is an important one. I think that we can breed cynicism about what we do and propose if you just change the labels and not the content. It just sounds like you're trying to dress up something else.

To me there is a fundamental difference between what we describe as an accountable care organization and

Paul Elwood's definition of a health maintenance organization. The way we've used the term accountable care organization, I think, is this is in the context of fee-for-service Medicare. So it's a non-pre-payment method of trying to reward organized delivery of care and accountability.

So for example, in the group practice demo, which is sort of the closest embodiment, the basic payment method is still fee-for-service. And then there's an accounting of performance against targets, much as Arnie has described, and rewards. So the insurance risk remains with traditional Medicare and is not shifted to the provider organization, as in the case of Kaiser Permanente. So that is, I think, an important difference and worthy of two separate names.

DR. STUART: They're clearly not identical. As far as shared their risk, however, accountable care organizations, as we've seen, there is certainly implicit shared risk among the providers that are part of that. So think we have to be a little careful again in terms of you're right, there wouldn't be a capitation payment. But if all of the money came to a particular organization that then had responsibility for distributing it out, there are

going to be winners and losers in terms of who gets those funds.

So at the final end of the game you've got some of the same mechanisms working for you.

MR. HACKBARTH: Two ways of trying to achieve accountability through different payment mechanisms.

DR. BORMAN: To go to one of the things you brought up early in the conversation, Glenn, and that was the issue of synchrony or synchronization, and I'd like to just encourage that as a thought a little bit.

If I look at my particular world as a physician, I also look at providers and non-physician professionals, whatever, in terms of how you can reward us, if you will, for being better participants. You can give us more money, which clearly we're in a system that's not prepared nor capable of doing that. You can give us time so that you can do things that allow us to do our part of the system in less time. And somewhat linked to that, you can allow us to do it with less hassle.

Beyond its intrinsic value to me as being incredibly a wonderful thing to do, being in the operating room, it's also a period of time in my life where I'm pretty

much not hassled with thinking about business issues, delivery issues, whatever they may be.

I think that practitioners in all disciplines feel a considerable sense of hassle that to some degree relates to the dissynchrony, if you will. Everything we propose now is collecting more information, reporting more things, doing more things. And we are, to some degree, potentially increasing that hassle factor at a time when we want to reduce the money factor. And we're not exactly giving some time factor.

And so I would just suggest that this synchrony piece here may, in fact, represent something very important in building the culture change that Jennie has talked about allowing people to embrace that. So I think that would be one point.

I think another point relates to the issue of options and beneficiaries. Most people, and certainly not the very bright people in this room who think about health care and so on and so forth, but most people out there don't really know what they've bought in terms of their health care until they have to use it.

And so this notion that we can provide a whole

bunch of up front education and have no surprises when somebody goes to use it and to have complete satisfaction when they go to use it is not entirely realistic. And I think maybe what that says to us is that there need to be options for beneficiaries that not everybody -- and Mitra, I was struck, you said that you see a lot of people where cost is their primary motivator at their original purchase, if you will, of the benefit. When they have to go use the benefit, however, they don't necessarily remember that piece. There are other things they have values for at that point.

So maybe what everybody buys is something basic and then they have to have options either up front and/or at the point of service to be able to change or to add to the pot to get more. Because I'm constantly talking with patients who say oh, I never realized that this wasn't covered or I couldn't get this, couldn't do this, can't have that drug, whatever.

And so I think an expectation that a beneficiary up front can make a choice that will serve them well over a period of time, we may be imputing just a bit much here. And for me the practical piece of that is that we need to be

endorsing systems that do allow options, that recognizes that that complicates it.

MR. HACKBARTH: Nick, it's going once, twice.

DR. WOLTER: I guess I would make a pitch that this chapter, which is kind of the way we talked about it at the retreat, it does become a framework to refer back to.

And I do agree with Jack, it's not like we're hitting the Garmin device that will show us the exact roadmap to anything. But it could be a framework that helps us maybe every 12 to 18 months take a look at it and see whether these things are indeed creating a framework that help us to move into something better.

And Arnie brought up complexity theory, which we've spent a little time on my organization. I think the idea that you do multiple small things that add up to something bigger than the sum of them -- that's called chunking -- there's some truth to it.

Mark, you in essence said that without using that phrase. And I think there's a lot to that, which is why we do need to look at this again in a year or a year-and-a-half so it just doesn't become the 2008 June Red Book chapter that is dusty.

I think that would have value if we could use this reference over and over again to try to stick to some of the principles.

I really like the IOM six aims, for example, and what are these multiple small actions that might move us toward those six aims. So since I won't be part of that annual exercise, that's really my pitch without commenting on some of the specifics, many of which I like, in the chapter.

MR. HACKBARTH: Thanks, Nick, for that.

DR. MILLER: We're way over time so we can't discuss this --

[Laughter.]

DR. MILLER: No, no, no. I'm not going to make pronouncements. I want you guys to track on -- your session yesterday was on the updates and how upsetting that was. And part of this was, particularly the questions at the end were to tease some of these out. Let me just give you a couple examples.

Nancy made the point about consolidation and its potential effect on the -- why is the private sector unable to extract deficiencies? Good point. Think of it at the

philosophical level. We're talking about building larger organization, ACOs, that type of thing.

Even though it's a small point and you think yes, that's very logical. In a philosophical sense, we have to think about that because it runs in the other direction.

And just very quickly, on Karen's point, everybody wants accountability and the providers want less hassle. So there's no resolution but these small points actually do have large ramifications.

That was it. I'm sorry.

MR. HACKBARTH: Thank you. Well done.

Our final session is an update on our episode grouper work and Jennifer and Megan are going to do that.

MS. PODULKA: Good morning again.

We're sort of switching from really big picture on this last one to very technical, so I hope you bear with us. The interesting stuff is all at the end but we need to get through a few things first.

The analysis that we're going to represent was prepared by Thomson Healthcare using their medical episode grouper software. And we would like to, of course, thank them for all their work and assistance in getting us ready

for this. Their report isn't final yet so the results we're presenting are preliminary and subject to change.

Just an update, the Commission recommended in March 2005 that CMS use Medicare claims data to measure fee-for-service physicians' resource use and to provide individual physicians with confidential information on their resource use relative to their peers. The Commission has been exploring the use of episode groupers which group claims into clinically distinct episodes adjusted for risk. Our past analysis of both the MEGs and ETGs episode groupers show that it's possible to use these software packages with Medicare claims to measure physician resource use. Both groupers in our analysis assigned more than 95 percent of claims to episodes across the six MSAs that we studied. The types of episodes to which claims were assigned also appear to have face validity. For example, most psychiatric hospital claims grouped psychiatric episodes.

However, in our earlier work we felt that there were some technical and analytic issues that would need to be resolved before final implementation.

One of those issues that we needed to explore is whether there is year-to-year stability in physicians'

relative resource use. We had not been able to do this in the past because we only had episodes for one year, 2002. Because we have added an additional year of claims to our dataset, we now can analyze episodes for 2002 and 2003. This allows us to consider the stability of physicians' resource use results over two points in time. Stable physician scores would add to our previous results to further indicate that episode groupers are suitable for analyzing Medicare claims.

Of course, this would be true if most physicians' practice styles remain relatively the same from year to year. We understand that, of course, some physicians' practice styles may change over time, especially if their circumstances change. For example, if they see a different mix of patients or treat different types of episodes.

Before I tell you about the stability results from the analysis, Megan is going to briefly describe the methodology that Thomson used in their analysis.

MS. MOORE: Thank you, Jennifer.

I'm going to give a brief overview of the methods Thomson used and if anyone has questions I can answer them later.

In order to assess year-to-year stability, Thomson first decided to explore how physicians are compared to their peers. They chose to use two statistical models to compare physicians observed resource use to the average of their peers, which we refer to as expected. Peers here are defined as physicians in the same specialty in the same Metropolitan statistical area.

Thomson used these two models in order to explore different ways of accounting for the random variation we see when measuring resource use. Their two models build on the simple observed to expected ratios we have used in the past. In each case, the observed resource use is the same, and what changes is the measure of expected resource use.

Quickly, the multilevel regression is commonly used for physician and hospital profiling applications. Using this approach physicians differences from the mean form the basis for each physician's estimated efficiency score.

Monte Carlo randomization compares episodes to like episodes. So an episode is compared to other episodes of the same type, severity, and disease stage. Monte Carlo creates a distribution by randomly drawing episodes similar

to the physician's episodes and then compares the physician's observed resource use to the expected, which is represented by a distribution.

Using this approach, physician outliers are based on how likely the physician's resource use is given the expected resource use shown by this distribution of randomly drawn episodes.

I'll give an example but first note that both models yield similar results. So on the X axis here, you have efficiency scores for physicians using the multilevel model. And then for the same physicians, the Y axis shows efficiency score using Monte Carlo randomization. As you can see, these scores are highly correlated. Physicians who tend to have high scores under one models also have high scores using the other, and so on. In this session, given that results were similar, we're going to just focus on those produced by the Monte Carlo model.

For a quick example, each row in this table represents an episode attributed to an example physician. While we only show five episodes, this physician had 22. The last value in the table, $1,521, labeled mean, is this physician's average payment across all his episodes. The

Monte Carlo method works by matching each episode -- represented by a row -- to randomly drawn episodes of the same episode type, stage, and relative risk score. And then this is repeated 10,000 times, and each time a sample mean is created this has a mix of episodes as our example physician. Then we can compare their mean to this distribution, which we see on this slide.

This is the distribution of 10,000 sample mean payments. Based on these sample means, the physician's observed mean payment of $1,521 appears to be high. About 5 percent of the 10,000 sample means exceed this physician's observed payment.

This method has some flexibility and allows the analyst to look in more detail at a physician's performance by type of service because we can compare resource use to distributions separated by type of service. Physicians may find feedback that includes detailed information like this to be more actionable.

The results from the Monte Carlo and multilevel models were aggregated for all physicians in six MSAs to examine the year-to-year stability.

Now Jennifer is going to tell you about those

year-to-year stability results.

MS. PODULKA: This table here shows the correlations between the 2002 and 2003 efficiency scores, which are the measures of relative resource use, weighted by each physicians' average number of episodes per year. The correlations are quite high, indicating good year-to-year stability in the efficiency scores based on both models, the multilevel and the Monte Carlo.

Physicians with high efficiency scores in 2002 also tended to have high scores in 2003 and vice versa. Remember again that to the extent that physicians' practice patterns remain similar year to year, these efficiency scores suggest that the episode groupers are suitable for analyzing Medicare claims.

Those correlations in the table are for the universe of physicians across our six MSAs. We also further analyzed physicians' efficiency scores year-to-year when the first year scores qualified the physicians as outliers.

Before I talk about the results up here on the screen, I want to note that the analyst chose very high thresholds for identifying outliers. What that meant was that a physician was considered an outlier in 2002 if one-

tenth of 1 percent of the matched case-mixes using the Monte Carlo model exceeded his practice profile. And then if in the second year, 2003, he remained in at least the top 5 percent he was labeled an outlier in both years.

So with that in mind, using the definition, we found that there were 611 outliers in 2002. This was 3 percent of the total. And 572 of those 611, or 94 percent, were also outliers in the second year. The 6 percent of physicians who were labeled outliers in 2002 but not in 2003 may not have actually been outliers in the first year. However, it is also possible that they were truly an outlier in the first year and not in the second year because one would expect some natural variation in physicians' efficiency from year to year. Overall, those results are somewhat encouraging.

Which leads us to our conclusions from this work. The year-to-year stability results, both for the universe and for the outliers, are encouraging in that they suggest that we are measuring an actual phenomena of outlier physicians who routinely practiced inefficiently.

I want to note that the contractor has also looked at year-to-year stability results for a few specialties and

thus far those results are similar to the overall results presented here. Thomson Healthcare is finalizing their full report which, in addition to looking at stability, will also explore alternative attribution methods. You may remember from past presentations we've used a single attribution method for our own work and now we're exploring multiple attribution and some other ideas.

We plan to present those results at future Commission meetings.

We also plan to conduct stability analyses using the other episode grouper software package that we've used, ETGs. Of course, we'll come back around, too, to the discussion we had in September about appropriate ways to disseminate this information to physicians so that it's actionable and has a lot of input.

So with those things in mind, please let us know if you have any questions or additional analyses that you'd like to see included for the future work.

MR. HACKBARTH: Thank you.

My palms start to get clammy when my lawyer mind sees Monte Carlo randomization model. So let me just make sure I'm oriented as to what we're talking about.

So basically what we're doing is stress testing, as it were, the technique of using episode groupers to analyze claims. This is good news. The consistency, the stability and results is what you would want.

Having said that, it doesn't prove that we have a great tool yet. There are still issues such as Nick raised yesterday when we talked about this, very important issues about the use of the attribution rules and how you attribute responsibility for what goes on. And there are many other issues, as well.

So this is focused on a very narrow thing and it's good news.

Physicians won't see any of this. This is all behind the curtain. We don't need to worry about physicians reviewing Monte Carlo models; right? Please tell me that's right.

[Laughter.]

MS. PODULKA: I imagine it would be a very select group of physicians who be that interested in the statistical underpinnings but I'm sure that --

MR. HACKBARTH: It needs to be available.

MS. PODULKA: It would be available and physicians

would, I'm sure, want to know whether they are likely to be stable from year-to-year.

MR. HACKBARTH: Yes, right. Okay, I feel better now and I can wipe the sweat off my palms.

MS. DePARLE: I've got sweaty palms, too. Maybe it's the lawyer thing, as opposed to the economists look calm here.

For this to be a tool that we can use effectively, it does need to be very accessible. And I think physicians would want to understand it. Look at RBRVS. They sort of had to try to understand that. And to the extent they don't, it just creates hostility, puzzlement, derision.

I'm thinking that if it ever goes anywhere it needs to be either the Minneapolis method or the Meridian, Mississippi method, as opposed to the Monte Carlo method. That might go down a little bit better.

I want to make sure I understand what it is we consider to be resource use. What effect would a new technology becoming available have in this, our a new treatment? I see Dr. Bill Rich sitting there. A couple of years there were some major changes in ophthalmology where there were new drugs available and new treatments available

for macular degeneration. I would think that would have increased a physician's resource use a lot, not because he or she was inefficient but because there's a treatment available to really help somebody.

So how would we tease that out of it?

MS. PODULKA: Actually, it is encouraging as well the way these two models and the current episode grouper softwares function in the sense. As Megan mentioned, it becomes very specific in comparing like episodes to like episodes.

So as opposed to just doing a very high-level look, which is a good start, about total spending a physician, we're comparing that physician's episodes of that specific type -- so for a macular degeneration episodes -- to similarly severe patients. So not just all patients but women 65 with no comorbid conditions. And the severity staging of that episode. So is early degeneration? Is it final stages?

So in that sense, to the extent that physicians are now treating that type of episode, that's severity, and that disease stage similarly, you're comparing like to like instead of comparing it to a different type of episode with

a different type of treatment option.

MR. HACKBARTH: The reference point of similar physicians in the same specialty in the same community should help address it.

DR. REISCHAUER: The issue is early adopters of new technology.

MS. DePARLE: Those people would be outliers.

DR. REISCHAUER: It depends on what you're going to use this stuff for. But if you're really looking at the top few percent, a lot of this can evolve into a conversation and they should realize -- it should be so evident that their resource utilization is so much greater than the average that the discussion would lead to fruitful reduction in resource use. But it's not going to lead to a great deal of savings.

MS. DePARLE: Yes. If you use it the way you said, it won't.

DR. REISCHAUER: If you were talking about the top one-tenth of 1 percent or whatever. When you bring the threshold down, then the complexities of this type begin to multiply.

DR. MILSTEIN: I think Bob's comments also would

apply, even if one were using a less extreme definition of outliers. If one, for example, were to use what the GAO used in their report last year, that was I think -- they had a standard deviation but in the end it boiled down to just 5 percent. But if you said what would happen if essentially those what appear to be inefficient practice patterns were brought back down to the average, it generated quite a bit of savings in the GAO model.

The other comment I have with respect to Nancy-Ann's question, is that it sort of signals one of the interesting positive consequences of using these groupers, is the impact of a new technology -- for example, let's say Dr. A adopts new technology much more quickly than his peers and as a result his comparisons, even on an ETG or MEG adjusted basis is going to look different. But it could look different in either of two directions. That is, if the new technology -- even if the technology is more expensive -- reduces total resource use, it's going to make their profile look more favorable or vice versa. And because of the vice versa opportunity, that's why quality ratings also have to be judged concurrently.

But I think it wouldn't necessarily push in one

direction or the other because it's the impact on total resource use that becomes relevant for this analysis.

MS. DePARLE: I wasn't finished but I do think, to your point, we have to be careful how we use the word efficiency. And to the extent we can, we have to factor in quality and outcomes with this.

Now that's going to be very hard, and we have to start -- as my friend, Bob Reischauer, keeps telling me, we have to crawl before we can walk here. But I'm just concerned about how this would be received if we just talk about efficiency in a very narrow way.

As we go on in this, I think it would be really useful for us to have some -- I think doctors call them vignettes -- something that could show us in a more granular way some episodes compared and what the resources actually were underneath the big number. At least I'd be interested in hearing that and some of our clinicians on the panel could tell us whether it makes sense to them.

DR. CASTELLANOS: I guess I have a couple of questions. Last year somehow I remember CMS, Herb Kuhn, said that this data would be available in the spring of 2008. Do you know what resource use on the physician level?

He said it was going to be available. Do you know if it's going to be publicly available, personally available, or what?

DR. MILLER: We had a conversation -- I want to say a few weeks back. What Herb said there was with the proper resources and attention and focus we could have the capabilities of producing data like this. What's happening in the organization is they have been working along these paths, too, looking at these same kinds of groupers and how they behave, I think in part spurred by the fact that we were doing it. They are not up to the point where they're just about to release or put that information out.

What he was trying to say in front of the Committee was if this is what you want, with the proper focus and resources we can get to the point of putting that data out. But they aren't at that point now.

MR. HACKBARTH: Which is one of the reasons, Ron, that I think we recast our recommendation on this. When we first talk about episode grouper we said CMS ought to do this. The recommendation that we voted on yesterday was a recommendation to the Congress that the Congress ought to tell CMS to do it. That was the reason for that change.

DR. CASTELLANOS: A couple of other points. I agree with what Nancy said. Somehow we have to factor in quality, outcomes, and it has to be risk-adjusted. It's just not macular degeneration. It's the impact of the risk. And that needs to be -- if this is going to be given out, we need to risk factor in all of these.

DR. MILLER: I want to be sure that everybody understands here how much risk adjustment is present. I mean, there's two levels of complexity going on here. The dilemma that we have is we could have showed up and said it's highly correlated, things are stable from year to year. And then certain people at this table would have said well, how would you know? Do you know that? And Meg was insisting that she wanted to present these models.

[Laughter.]

DR. MILLER: That we went through the grinding of the data, so that certain of you who have those kinds of minds could go oh, I think I understand how you did this.

But there's two levels of severity adjustment going on here. The groupers themselves actually do things like stage by disease, stage by condition, disease, risk score to put physicians into comparable episodes. Then

there was some additional statistical analysis on top of that that said I want to control for some random variation here and then make a comparison to some distribution. And really all those two models were doing were giving you different distributions to compare physicians to. That's all they did in a little fancier and more complicated way.

So in this analysis that we put in front of you, there's actually a high degree of risk adjustment going on. And particularly when the analyst chose -- in addition -- set a very high threshold to identify an outlier here. So this is a highly conservative approach to identifying outliers, I would say.

DR. CASTELLANOS: I appreciate that.

A couple of other things. I like the comments on new technology because you don't want something like this impeding progress in medicine. Unfortunately, sometimes new technology is a gang buster and sometimes it's a balloon, it's a lead balloon that doesn't fly. Unfortunately, without good comparative effectiveness information we don't have that. Sometimes it's being the first kid on the street with new technology is good and it's bad.

The last point, and it's really a positive point.

As you mentioned, the GAO study did come out. And there was an issue in that of 12 communities that the communities had high resource use and outliers in each community. It wasn't the top 12 but it was just, my understanding, 12 random communities.

Well, fortunately or unfortunately, one of those communities is where I live. And let me tell you the impact that had. The hospitals picked that up, the community physicians picked it up. And I'm saying to you that I think the people in that community are looking at what they're doing a little bit more carefully and really looking on their practice patterns.

Now obviously, it's not the individual physician, but they labeled the community. And I think it did have a positive effect.

MR. EBELER: It may be a follow-up on that. It would be useful to see, you mentioned at the end differentiating between this as an analytic tool which you are validating and then thinking about it as a communications and behavior change tool.

It would be useful to see what a report back to a sample physician might look like, what a report at a

physician level might look like, at a community level might look at like, at a hospital, just to get a sense of how people out there could grapple with this and identify things.

DR. MILLER: No problem on that. Jennifer has actually developed one for some other kinds of briefings we were doing. We were on the Hill over the last year with GAO to talk about it. And she had put together a little thing and we can bring that through and make sure that you see it.

MS. HANSEN: Just to build on that, and I think with, Ron, your example and, Jack, your comment.

I'm struck by when CMS gave some data back on some cardiac surgeries. And I think it was Nevada or Utah really got some really poor results for a community. In it caused that whole community apparently to pull together and find out that transportation was really one of the issues.

So I wonder if you could build in this point about what does it do to change not just the individual practice but how even a community itself has brought together the hospital, the ER ambulance system, really to say there's a different model in this community that's rural that has to address the data that comes out of CMS.

DR. BORMAN: I'm going to assume that the Monte Carlo part suggests that there is some origin in game theory to at least a part of this. And frankly, I'm pretty comfortable with that because when we actually look at examination security in board certification examinations, we use some models that, in fact, come from gaming theory in terms of looking at levels of potential cheating. And so if you like, I also hear it called queuing theory. Maybe that makes it more comfortable than Monte Carlo for you attorney-type people.

I personally like this a lot in the sense that it embodies a couple of things. Number one, it embodies a relatively smaller step, but one that in aggregate with other steps is a build toward something else. I think there's no question that that's a case here. And as we look for those, this is one that may not achieve gigantic savings. But it is a building block and it's one that seems to be coming within reach in a pretty credible way.

The second thing about it is that it avoids a potentially draconian action against all to target on a relatively smaller number where the bigger problems are. In that sense, I think it has enormous value as a principle.

It gives it credibility as a place to start.

If you could go to the slide where you talked a little bit about the one-tenth of 1 percent and that kind of thing, and I would just ask was there also some sensitivity analysis done? That is, for example, if you wanted on the second year to get to 100 percent, what did that mean in retrospect, that one-tenth of 1 percent of 600 or whatever? What would that number have to change to get to 100 percent in the second year? And similarly, the other way around. With varying the first choice, how much -- how sensitive -- where do you have to set the bar to get sensitivity and specificity?

DR. MILLER: The answer is that there is no sensitivity analysis that we've done to this point. But what would have to happen in order to capture 100 percent -- and you guys make sure this is right but I'm pretty sure this is right -- is in the second year you would move to a wider standard than 5 percent. But we're just kind of rolling this out, seeing what your reaction is.

DR. BORMAN: Because I think that physicians actually, in many ways, will leap to understanding of the sensitivity specificity piece here fairly quickly because we

talk about that in terms of therapies and drugs and a variety of things. And I think that when you are screening for something -- and in this case if we think of it as screening for behavior that we'd like to report on and correct -- then you want the sensitivity here to be maximal and not worry so much about the specificity.

If we're trying to say that we want this to be absolutely credible and reliable that everyone we label as an outlier is indeed an outlier, then we're going for 100 percent specificity.

I think that will relate to how we present it to people. And the sensitivity analysis to get to 100 percent sensitivity versus 100 percent specificity may help us know how to use it as we go to roll it out. Looking at these practical examples of what a report will look like and stuff will help to answer that, as well.

DR. MILLER: I think your point is really well taken. And I also think it's the former, at least for starters, rather than the latter, the notion of trying to identify blocks of physicians where there's got to be some interaction, as opposed to at least initially saying this is absolutely where you are and here's know what's going to

happen.

DR. BORMAN: I would agree with that.

DR. REISCHAUER: Unless I've misunderstood what's going on for the last 45 minutes, I think it's impossible to get to 100 percent unless certain people, physicians, for genetic reasons were outliers and there was no randomness in this at all.

DR. MILLER: That's what I'm saying, I think it's the former concept, the first concept, that says no, it's not about getting to 100 percent. The sensitivity here doesn't have to be down to the exact --

DR. REISCHAUER: But you identify people who have used lots of resources in year one, and there's lots of reasons for that. And some of it is just that they're inefficient. But there are others who randomly bad draw, in another year are the lowest.

DR. MILLER: The other thing that this kind of analysis entered -- we didn't say anything along these lines -- but the other thing that this analysis begins to allow you to think about is if you watch a physician's performance over one year or two years and the person occupies the top year after year, you're starting to get to the genetic issue

that Bob is pointing to.

And so with multiple years and this much stability, you can start to say look, I'm telling you, you're showing up every time.

MR. HACKBARTH: Last comment, Jack.

MR. EBELER: Can I just ask a risk question here? As I understand it, there's a presumption of a norm here. And the norm is current practice statistically aggregated.

One, overall we're presuming the norm is pretty expensive and inefficient, when you look at national numbers. Is there a risk here that those at the low utilization end, particularly in some practices, will say gee, I could be generating more fees? There's norming and renorming that I just think you have to worry about it. I don't understand how it works.

DR. MILSTEIN: Is up to the user -- in this case CMS -- as to what the frame of reference for right is. You could use either the average, which would incur the risk that you just described. Or I think one of the things we heard described when Virginia Mason came in to talk to us is using the subset -- within a given specialty using the specialists that are at the top of the charts, both on

quality measures and resource use measures. Top of the charts meaning most favorable, lowest resource use, highest quality.

I think it's a great question and I would hope in whatever model reports that we formulate that Medicare might use we not only use as the normative frame of reference what's average in your specialty but also what represents the pinnacle in your specialty in terms of that subset of peers that are getting the highest quality scores with the lowest amount of total resource use.

MR. HACKBARTH: It might be interesting, if there was a really good group or delivery system that uses this tool, just to hear somebody present here is how we use it, here are the issues that come up, this is how we try to deal with those issues.

DR. REISCHAUER: Our IOM panel, some of you might remember, had several presentations along these lines, where providers were divided into four quadrants, and they tried to analyze the high quality low resource use groups and see what does define them. We can get that information.

MR. HACKBARTH: Any other comments?

DR. SCANLON: It was slightly related to this. We

did a study once where we were, in some ways, looking at something equivalent because we were very narrow in terms of the diagnosis and the kinds of treatment, and identified this distribution and had clinicians review it. And there was a clear pattern of underuse among some providers. You can use it also for counseling, saying this is clinically necessary, why isn't it happening?

MS. BEHROOZI: My palms are still sweating, so this isn't a technical question. Just actually following on what you and Bob were just following on Glenn. The wheel is being invented in lots of different places, whether it's other policy organization or whether it's private payers. I wonder if we could have, in the future, some kind of survey sort of what else is going out there and how this might measure out and figuring out the best practices so the wheel doesn't have to be reinvented too many times. And particularly, if you're doing the most in-depth careful analysis, putting it out there as a model.

MR. HACKBARTH: Okay, well done. Thank you.

We'll now have a brief public comment period. Dr. Rich knows the ground rules well. Please identify yourself and keep your comments to no more than a couple of, please.

DR. RICH: Thank you, Mr. Chairman.

My name is Bill Rich. I am Chair of the RUC and Director of Health Policy for the American Academy of Ophthalmology. I'd like to address the staff presentation on groupers.

I think that there is a lot of work that is already being done, and I'd like to raise some of the access issues that grouper analysis has led to.

In 2006 some of the staff members of MedPAC and myself met in Chicago with the Ambulatory Quality Alliance Cost of Care Group to look at both grouper commercial products that were discussed here.

Unfortunately, these are very, very -- they're proprietary. And there is no physician and no analysis has been made of what underlies the assumptions of the risk. And I must disagree with Mark a little bit. The risk is imputed with claims data. And the problems when this is applied to the population -- and both of these products are used extensively now. The N, as staff pointed out, of 26 has been shown not to be statistically valid. The N is 76. So all of a sudden you have an analysis within the staff report which has been rejected. I don't know anyone that

accepts that.

The implication of that is that this is unable to identify really truly risk-adjusted patient populations and physicians who care for them. This is widely used in Massachusetts and Texas.

What we see now, the inability to really identify complex patients, is this is tied to tiering. That's how money is saved. In Massachusetts every glaucoma specialist is tiered at the lowest highest copay. That means the patients with end-stage disease have to pay more. Why? Because this software is unable to identify complex glaucoma patients so their utilization of resources and surgery is higher. Duh.

The same thing with ocular plastics. If someone has a tumor on their lid, I save it off in the office, no problem. However, if that tumor requires Mohs dissection, that gets referred to a subspecialist. In the state of Texas every single ocular plastic surgeon and every patient with invasive carcinoma of the face is tiered at a higher pay level.

So you have to really understand the proprietary nature and the assumptions have no validity at all and

absolutely no transparency. CMS recognizes this and that's why you have not seen the release of the physician use reports.

The medical community was hoping that this would let us get at churning. It has not. So I would urge a little caution and a little further analysis of looking at maybe the 5 to 10 percent outliers. You're going to find not just the churners, but you're going to find stick patients and the doctors who care for them.

So I would urge a little caution and a little further analysis before making really strong recommendations.

The issue of tying it to quality is a major concern of the medical community, a major concern of CMS. And there have been some new studies that have been funded with CMS to really kind of look at this issue. How can we truly risk-adjusted this?

And again I'm going to stress, the risk adjustment is based on claims data and no one understands the -- there is no transparency to see if that really does reflect sick patient and the docs who take care of them.

Thank you.

MS. WILBUR: Hi. I'm Valerie Wilbur with the Special Needs Plan Alliance. I just wanted to make a comment on the recommendation that was discussed today, which would include the institutional population along with the duals as being excluded from open enrollment for special needs plans.

I just wanted to start out my comments by saying that the SNP Alliance overall is very pleased with the recommendations you're submitting to Congress on SNPs. We think they're going to raise the bar on SNPs and prevent MA plans that aren't really interested in targeting and developing specialty programs from coming in and making sure that targeting and specialization is a part of the SNP program moving forward.

But I think closing down open enrollment for beneficiaries like the institutional is inconsistent with what Congress had in mind. I think the reason that SNPs were created is because Congress didn't think that people with complex chronic conditions and complex medical needs were being well served by fee-for-service and regular MA plans, and so they created this specialty model that would address those needs better.

So by closing down open enrollment and not allowing people like the institutionalized from getting into the SNPs at the time when they demonstrate that need is inconsistent with the idea of being able to go ahead and provide the services that are needed when they're needed so that they can have a better impact on health outcomes.

Now we really appreciate the change that you made to the dual population where you're going to allow dual SNPs that have contracts with states to go ahead and maintain that open enrollment because it's going to allow SNPs to do the coordination between Medicare and Medicaid, which would have been prevented under the closed enrollment rule. So that's very good there.

But with the institutional population, we have a concern about the clinical issue that's involved. I think people that are placed in nursing homes and other institutions have the most significant medical needs. One of the things that institutional SNPs are intended to do is help keep people out of hospitals. Hospitals are very dangerous places, as you all know, for people that are frail elderly. They have all kinds of adverse impacts on health care. And so to require people that need institutional care

to wait up to a year to be able to get access to those SNPs is going to interfere with that.

I guess what I'm asking is the way to deal with the concern of closing down -- the reason for the recommendation about closing down open enrollment -- was I think that there were plans that were setting themselves up as SNPs as a way to get around the closed enrollment or the lock-in rule.

I think a better way of dealing with that without interfering with the ability to get to the clinical needs of people when they need it is to do what you did with your other recommendations. Make more stringent requirements for the way you define chronically ill. Require special evaluation methods for SNPs to show that they're really doing something different from other MA plans. Require SNPs to have contracts with states so that you can go ahead and facilitate that coordination.

So I guess what I would recommend is that assuming Congress goes ahead and accepts some of those recommendation that create a higher bar, which we very much support, I would suggest that you go back and revisit that open enrollment rule so that if SNPs, in fact, start really

targeting the high-risk population and developing those specialty interventions as a result of some new legislation Congress may pass, that you would consider reopening the enrollment period so people can get access to these specialty services when they're needed.

Thank you very much.

MR. HACKBARTH: Okay. We are adjourned.

[Whereupon, at 11:14 a.m., the meeting was adjourned.]

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