MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 24, 2003
9:40 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Using incentives to improve quality in Medicare
-- Karen Milgate, Sharon Cheng

MS. CHENG: This is the final presentation of material for a chapter in MedPAC's June report on using incentives to improve quality.

The first two presentations introduced the concept. In this presentation, we'll focus on the conclusions we drew from the private sector and the recommendations it suggests for MedPAC's demonstration of financial incentives.

Karen will outline implementation issues for incentives and suggest two settings where measure sets may be mature enough to make a demonstration of financial incentives feasible. Finally, we'll discuss ways that Medicare can address quality improvements within two dimensions: within settings and across settings.

On this slide is a brief review. This is the case for why incentives are important. Throughout health care, and Medicare is no exception, payments for health care are not designed to reward high quality. High quality plans and providers are paid no more than others with lower quality. In fact the system pays more for low quality. For example, when a hospital stay receives a higher reimbursement due to a preventable complication.

In this system, in fact some providers may be especially frustrated if they make the investment in a quality improvement and the savings are accrued by another provider somewhere downstream.

Both private and public purchasers have looked to incentives to improve quality because they provide a means to align the payment with the quality of goals. Incentives can reward those who invest the time and effort in making the improvement. By attaching a real value to quality, incentives may help to foster a culture within plans and providers that encourages their leadership to emphasize quality improvement, recognize contributions throughout the organization toward the quality of care, and reward investment in the information technology that supports clinical decision-making.

Incentives would be only one part of Medicare's current efforts to improve quality. Medicare currently in the role of regulator enforces regulations such as the conditions of participation to ensure quality. Medicare is also a significant sponsor of research in the quality field. Incentives themselves are not an entirely new concept for Medicare. In fact there already is some use of two types of non-financial incentives: flexible oversight and public disclosure, already in the program. Medicare applies flexible oversight to allow M+C plans who have already achieved high levels on mammography screening, for example, to not undertake one of the additional national quality projects that would otherwise be required.

Medicare also uses public disclosure of quality information

for M+C plans, as well as dialysis, SNF, and at the end of this month, home health providers. Medicare has already started to identify and use quality measure sets and develop standardized data collection. It gives feedback to providers and plans regarding their own performance within a number of settings. Through public disclosure and the QIO program, these efforts are keys to building the infrastructure for financial incentives.

Medicare has also become some efforts in the demonstration field. For example, Medicare is testing shared savings to improve care for beneficiaries with chronic conditions. Physician groups are paid a bonus based on the expected versus actual use of care. Those savings are distributed, in part, based on the quality of care that beneficiaries receive.

So to get an idea of where Medicare could turn next to develop incentives, we look at the private sector. We identified six key types of financial and non-financial incentives, and then we talked to a number of plans, payers, and providers and experts in the field to see what was being used in the private sector, and what lessons had they learned.

A key finding was that one of the most prevalent incentives in the private sector was payment differentials for providers. This incentive works by setting goals for providers or plans and giving a monetary bonus or an additional percentage to those who meet the goals. We identified this incentive as one of the most promising, and Karen will present a draft recommendation of this incentive as Medicare's next step.

Another finding was that provider payment differentials appear to work. Results from Blue Cross-Blue Shield, Buyers Health Care Action Group, and others in regions as diverse as California, New York, Michigan, and Florida have all been positive. We found that many payment for provider differentials got their start as a negotiating tool. Just as private payers have been approached for increases, so too has Medicare and then Medicare would use similar response in asking for accountability for value in response to higher rates.

However, we heard consistently that the hard part of implementing this kind of incentive is finding the right measures and collecting and analyzing the data to be used to compare providers. These issues must be addressed in addition to others posed by Medicare's size, which is large compared to the private purchasers and plans that we spoke with, and Medicare's population, which is probably more vulnerable than the plans and the payers in the private sector that we spoke with.

Now Karen will pick it up and outline the implementation issues that Medicare will face.

MS. MILGATE: As Sharon noted, some purchasers and plans in the private sector have used provider payment differentials and found them to be effective. Medicare, as the nation's single largest purchaser, could actually lead further efforts to use these incentives to improve quality. However, the program's size, while an advantage, is also a disadvantage and could create a variety of implementation issues. Identifying, collecting, and analyzing data needed to compare providers is an administratively complex and difficult task. A confounding factor to this is that

a wide spectrum of providers participate in Medicare. They participate in different regions, with different populations served. They are very different sizes. A 30-bed hospital would have to be compared, for example, with a 300-bed hospital. And their ability to collect data and commit resources to improvement varies widely.

In addition, with this much focus on specific quality, within specific quality areas, could hinder further quality innovation, taking attention away from other possible important measures. And the evolution of measures would also be important. If CMS were responsible for evolving measure sets, for example, there may need to be broader public input than you might have to have if there was a private sector to evolve to new measures.

Finally, because of the limitations of current case mix adjustment mechanisms, putting in place provider payment differentials could disadvantage providers who take sicker patients. Some providers may actually receive lower scores because they take sicker or more complex patients, not because they provide lower quality care.

However, there are some potential solutions to these implementation issues and the private sector has used some of them. On this slide we provide some examples of how the choice of measures and payment distribution methodologies may address some of these implementation issues. In some settings where we don't have good risk-adjusted outcome measures one way to address that would be to use process or structural measures such as implementation of a particular type of technology. The private sector has looked at computerized physician order entry, for example, or the types of process measures that are used in the QIO program.

Another way to address some of these implementation issues is to use measures that are already widely used. For example, these would tend to then be less likely to stifle quality innovation because they would be building on efforts that were already underway, so it wouldn't be taking attention away from problems that are already receiving some focus.

In addition, by focusing on widely used measures, it would reduce complexity. You wouldn't have to have a program, develop new measures, a whole new data collection system. Those would already be in place. One way to try to address some of the issues through the payment distribution mechanism is to apply -- to try to develop your goals so that they're based on improvement rather than a specific attainment goal. In the private sector, most of the time they did actually set: these are the goals we want to reach. You reach them, you get the bonus. If you don't reach them, you don't get the bonus.

However, because Medicare deals with a wider spectrum of providers it may be important to actually look at improvement rather than attainment, or to do some mix so that you're actually making it possible for a wide spectrum of providers to obtain the financial incentives.

Another way to try to address some of these issues is to reward performance on a domain of care, such as diabetes or heart care. Choosing a particular domain of care addresses several of

the implementation issues. One is, it addresses administrative complexity because you wouldn't have to develop various matrix of measures. You'd go straight for one condition and not have to have a variety of different types of measures in your measurement toolbox.

In addition, one would suggest that if you chose a domain of care it would probably be on something that would be fairly prevalent, so it would also be able to be measured in a wide variety of providers, and you would also suggest that this would be building on current private sector efforts so it shouldn't take attention away from important quality problems.

CMS has several initiatives already underway, as Sharon talked about. We believe there are several concrete ways to move forward with provider payment differentials. Given the level of development of measure sets and data collection efforts, we identified two settings where demonstrations tying payment to quality might be most feasible. We believe this because we think that the way the measure sets are developed and already being collected actually address many of the implementation issues.

In Medicare+Choice plans that is already well-established through regulation. There is also a data collection methodology established, and it includes auditing. In addition, the way that measures evolve in the M+C program is actually in the hands of an independent organization, so CMS does not have to take it upon themselves to evolve the measures as they go forward.

In the inpatient rehabilitation facility setting, again, the measures are well established. In this setting we're talking outcomes, risk-adjusted outcomes measures of functional independence. They're broadly representative of what those organizations do. The main purpose of rehab is to improve functioning, so using functional improvement measures clearly measures what they do.

In addition, there's a standard data collection tool. The inpatient rehabilitation facility patient assessment instrument, the IRFPAI, is actually the basis for these measures. That tool is also used for care management and payment purposes, so it would not create an extra burden on those organizations. The chapter also outlines proposals for how payment could be distributed within these settings in a demonstration project, but we're not going to go through those details at this time.

In other settings, the infrastructure is not so well developed. In hospitals, for example, there are a variety of measures that could be used, but no core set has as yet been identified, and there is no standardized data collection tool. However, there are several efforts already underway in CMS to try to identify core sets. This is also in tandem with other organizations such as JCHO and the National Quality Forum.

But one effort they do have underway in tandem with various private sector groups is their voluntary public disclosure effort for hospitals. These measures that they are starting to identify for hospitals meet many of the criteria we've talked about in terms of how they would address some of the implementation issues. So through research or demonstration, CMS could evaluate the outcome of this initiative to identify core measures and data

collection methodologies for applying payment incentives.

In the physician world, measures are available. However, they're limited to certain conditions. It's often too hard to get enough patients in one condition to get a good enough sample size, and also hard to compare individual physician offices because they take different types of patients. However there are some efforts, even in measuring physician office quality, to try to measure in particular conditions.

For example, there are some private sector initiatives to look at diabetes care and heart condition care in physician offices. And some recent research has shown that as few as 35 cases, at least in one condition diabetes, might be enough to actually characterize the quality of diabetic care for that particular physician.

Another way that the private sector approached physicians was by focusing on group practices rather than physician offices, and that might be another interesting venue for CMS to begin to look at. And in fact, they actually have a couple of demonstrations where they're trying to look at different ways to pay group practices that are tied to some quality measures, as well.

In addition to focusing on improving care within settings, demonstrations could be designed to use payment differentials to prove care across settings. Because beneficiaries are living longer periods of time with one or more chronic condition, they need ongoing management of their care across settings and also in their home. This is particularly true for the seriously chronically ill and while it is difficult to design incentives based on individual beneficiaries or care for a certain population, Medicare could measure contribution each setting makes to improving this type of care.

I have a couple of examples here and in the paper, but for time I'll just move forward to the draft recommendation.

So in this presentation we summarize what's in the chapter, including issues CMS should consider in designing demonstrations on provider payment differentials, and at this time we would appreciate your comments on that guidance as well as the recommendation itself.

The draft recommendation reads the Secretary should conduct demonstrations to evaluate provider payment differentials that rewards and improve quality.

DR. NELSON: Would you please, again, say the penultimate question that you wanted us to consider?

MS. MILGATE: We were asking for comments on the guidance that's provided in the chapter to CMS about how to structure demonstrations, some of the ways you could use measures, that kind of thing.

DR. STOWERS: I just had a comment. That's a good chapter. But it was a little bit on the tone of going after the Medicare+Choice and the inpatient rehab. I know they're kind of low-hanging fruit, but I'm not sure it gives appropriate weight to the other vast majority of the Medicare beneficiaries that are going to be left out by the Medicare+Choice, these two very small segment of the population.

I'm afraid if CMS goes after this low-hanging fruit, looking at all the other barriers that we're kind of listing here, there could be considerable delay in getting after what we all know we need to do, and that's find a way to measure quality in the doctor's offices, in the hospital setting, in these others.

So I really see a greater importance over all to do all of this other lists than to do the list that we're telling them maybe should be the place to start. I don't know if I'm expressing that very well but there's a tone there that we're --

MR. HACKBARTH: Is it just a matter of the tone? Or is it a matter of --

DR. STOWERS: Or of priority.

MR. HACKBARTH: Is a matter of beefing up the language that says these are low-hanging fruit but certainly not the whole of what needs to be accomplished.

DR. STOWERS: Maybe putting a little more important on --

MR. HACKBARTH: Or alternatively, are you saying that if they devote their resources to these two they won't get to the others and therefore you don't want them to do M+C and inpatient rehab?

DR. STOWERS: I just think there needs to be a little bit more global orientation to the impact of impact of working on these two compared to the impact of working on the larger, more difficult ones.

MR. HACKBARTH: You don't oppose starting with these two, but you really want a strong emphasis that this is just the beginning and not the end.

MS. MILGATE: That's definitely fair. In fact, I meant to talk about that in the setup. So it needs to be a little stronger.

MR. FEEZOR: I know it's late in the morning and I've been a little bit negligent in not getting some of my thoughts back on this earlier, but three quick technical issues and then a statement, I think following up on what Ray was saying about a greater sense of urgency with getting on with the larger Medicare population and expenditures, not just on the areas that we seem to have the most track records.

First is we talk about the public disclosure as being one of the areas and that it enhances consumer choice. I think what is really important is not so much the choice. That's more of a political good you talk about here in Washington. But really is the knowledge and understanding of, in fact, the tremendous variations in quality and of what one actually needs in terms of health care.

So when we use choice, I think we probably ought to talk about knowledge and understanding perhaps of health care variations and their need.

Second, and I guess I'll ask David if he'll confirm this or not, the reference on the GM efforts to prudent plans, or to create a better performing plan is for salaried employees. I don't think that's for the -- we probably need to make sure that's reflected.

And then the other observation, in sort of the highlighting the innovations going into being done in the private sector, we

reference the tiered provider networks in the back end of the chapter but didn't do anything in the front end, as I recall. And I think that's going to be a -- to the extent that some of the tiered networks are trying to, in fact, base it not just on price but on quality, that probably bears a little bit stronger mentioning on the front.

Those are more of the technical observations. I guess as I read this chapter, I thought that we were being extraordinarily tepid at a time where urgency, indeed leadership, needs to be called for.

First off, let me back up. The criteria for the incentives, I think, were very sound and well laid out. But the fact of the matter is that Medicare currently does use financial incentives, primarily for either higher or lower quantities, either in fee-for-service or in terms of DRG-based.

But I guess I would like to make us a little more sense of urgency that Medicare needs to be moving as rapidly as possible in incentives. And I would say not only incentives that simply impact quality, but the other measures of performance that have been called out by IOM. And that's including not just clinical quality but patient experience, timeliness and efficiency.

I think that I would like to, maybe in a second iteration if we come back to this topic in another year, that certainly we ought to address the question of whether, in fact, that part of CMS's explicit role is, in fact, public disclosure efforts, the information they have and in collaborating with perhaps private initiatives to, in fact, making provider-specific measures more broadly available.

So I'm probably going a little bit rabid here compared to what Ray was comfortable with, but it does emphasize, I think, that we need to begin to go beyond quality to larger performance than, in fact, that we should look to try to measure that performance or provide collaborative efforts using Medicare data that, in fact, would begin to expose variation in individual performance and that we perhaps make a part of -- at least frame the question of whether or not a role CMS should be helping assist the disclosure of that information.

MR. HACKBARTH: I hear a couple of things, Allen. One is stronger language, language infused with more urgency. A second might be, I guess, even cast as a recommendation that CMS pursue provider-specific disclosure, which is something that from time to time has been controversial and they probably would welcome explicit support for that.

MR. FEEZOR: And I think the third thing, and maybe we can back into it by when you highlight what I think is trying to be done in certainly some of the private sector measures, it's not just quality improvement. It really is performance of the health care delivery system on a variety of factors and particularly those that were called out in the IOM report.

MR. HACKBARTH: What do you think about having an explicit recommendation? Recommendation doesn't quite seem the right word, but an explicit expression of support for release of provider-specific quality information? Reactions to that?

DR. NEWHOUSE: To paraphrase Orwell, some providers are more

equal than others. I'm not persuaded, based on the literature, that this makes sense at the individual physician level. But I think it makes sense for the institutional providers.

MR. HACKBARTH: Any other thoughts on that?

DR. WOLTER: I think it's already planned. JAMA just published state-wide data. My understanding is that those indicators, many of which do sync up with the IOM recommendations and what not, will at the institutional level be coming along in terms of public disclosure in the next year or two. I totally agree with it. I just think it's in the works.

MR. HACKBARTH: It's planned, but the history of this, in which I've had a personal part, is that it happens and then political resistance grows to it and then it sort of retreats for a while. Maybe it would be helpful if we had some explicit endorsement of that as a strategy for the long-term.

I agree with Joe's caveat about we're talking about institutional providers at this point, as opposed to individual clinicians, which I think is a vastly more complex area.

MS. DePARLE: I wanted to endorse what Allen said. I guess I feel rabid, too. I thought the background work in this chapter was very good and very comprehensive, a little too detached and I think that we should play a leadership role. I think that the administrator of CMS, Tom Scully, and the team there are really trying to do a lot of things to advance the cause of providing more information to the public and to providers, which I think will help to raise the quality bar and hopefully lower some of the preventable medical errors that the IOM report highlighted. We should have an explicit recommendation that supports what their doing.

DR. WAKEFIELD: I concur with what's been said to this point and also say, Nick, if people took a look at that JAMA article and the voted with their feet, a lot of folks would be seeking health care in North Dakota. I just want to point that out. When you look at those state rankings, we're right at the top.

Having said that, -- all the Lutherans, yes. Good high quality Lutheran care. I'm not one.

What I did want to say is in just in terms of tone, I want to reiterate -- although Ray made the point. As I was reading through this chapter, I was thinking gosh, I'm going to get to a recommendation that's going to have embedded within it M+C and rehab. So I saw that disconnect, too, as I was reading. I just want to reinforce that in that tone.

Secondly, I really like the inclusion, of course, of private sector efforts to date. I did wonder if we couldn't get a little bit more of a nod, and I would defer to other people more expert in this than I am, that's for sure, a stronger mention of public sector efforts in the sense of what the QIOs have been doing.

For example, in their current scope of work, I think they've got fairly widely accepted indicators of CHF, MIs, pneumonia, and surgical infections. I think the health care community, there's pretty good buy-in. I think there's pretty good data. And that hospitals that want to set up processes to implement efforts to achieve high-performance around those four areas can be helped by QIOs to do that, for example.

So I was just wondering if we might be giving a little bit of short shrift to what is there. Good reference to private sector but maybe a little but more of a nod to what's also occurring frankly through CMS' own good work.

Then I would just say, and I haven't settled in on any particular place on this yet, that those quality indicators, as I was thinking about them, they probably should be done, based on what I just said, about 100 percent of the time rather than improving to the 80th percent or ratcheting up. If there are good data and we feel pretty confident about what their measuring, you'd almost think gee, everybody should be doing them all of the time.

But having said that, I did wonder if there couldn't be or should be a little language in the text about maybe that's an area to pilot around too, those quality indicators.

So if we're looking at trying to incent performance maybe we look right at what is already coming out of the seventh scope of work in addition to -- and I'm not suggesting another recommendation. I'm just saying maybe in the text we can give a little but more of a nod to that effort, pulling that out just a little bit more.

If you find that what I just said is, in fact, the case.

MS. MILGATE: Yes, just a quick note. The measures that are part of the voluntary public disclosure that I referenced are actually derived from that. So we could certainly make that link more direct. But in fact, that's sort of what -- yes.

DR. WAKEFIELD: If you can make that more directed that would be great.

MR. DeBUSK: First of all, that was an excellent job on this chapter. This is certainly something that's certainly super important, important going forward.

In the potential solutions, as you can imagine, I was sure glad to see you say something about process and structure, after the last meeting.

In the first steps in other settings you talk about hospitals and physicians. And I noticed in the conclusion here, it says however, providing incentives for providers to improve care may also be a way of beginning to address concerns about variations in practice patterns.

Ultimately, as we go forward with best practice models and protocols, that's going to become a big issue. I'd love to see something more said about that in the text, because ultimately we've got to deal with that. And there is a wide variation across this country.

MR. SMITH: Karen, Sharon, I thought this chapter was extremely well done and I was rapid after I read it, so I thought it did a pretty good job of inciting, as it should have.

A question about the recommendation. Why just payment differentials? Why not beneficiary savings differentials? Several of the more interesting examples use that route. We don't talk about it.

MR. HACKBARTH: I was the one, David, who took us down that route, I think at the last meeting. The reason that I thought this was the higher priority, provider payment differentials were

the higher priorities because of the confounding influence of supplemental coverage for the Medicare population.

MR. SMITH: I agree with that, Glenn. I didn't think that was an argument for not exploring ways that co-payments might be used, borrowing a little bit from the GM experience.

Along the same lines, did I understand correctly that we wanted to add disclosure to this recommendation? Or do we want a separate recommendation?

MR. HACKBARTH: I was thinking in terms of a second recommendation, myself.

DR. REISCHAUER: I might not have many sympathizers with this point but I thought there was sort of a disconnect between some introductory sentences and the chapter as a whole. I'm just going to read one, which is Medicare has a strong commitment to quality demonstrated by its many efforts to measure and improvement it.

I think, quite frankly, historically it's been an embarrassment. This isn't to say that people at CMS haven't been concerned but this is a huge chunk of our health care system which lags behind both where private industry is and where states are. And it's in the basic structure of the program really, in that it is basically an all-willing provider kind of system and it does have as its board of directors the Congress of the United States, and it does serve disparate geographic areas. And that, by and large, those factors have kept it from being where it should be, which is at the forefront of the drive to improve quality for a particularly vulnerable and important component of our population.

I'd just like some recognition of that. If this sentence was right, it's sort of like why are you reading a 30 page chapter to pat them on the back?

The other thing that I would like us to emphasize a little bit more is I think this obviously can be done in bits and pieces and because of the way we have our payment system it really would not be hard to adjust the payment for one DRG here or there in the computer based on these kinds of things, and that we should, as Ray and Mary say, want to go ahead as rapidly as possible even if it were just in small areas for this.

Finally, you mentioned that there was sort of the trade-off between the levels and the improvement, how do you do this. There is the way around this dilemma and that is to have rising thresholds. That you start very low. You say if you achieve this level in year one you get the extra payment or you don't get the reduced payment.

But that level rises at 10 percentage points a year up to the threshold that you want to be at. Sure, it doesn't have a lot of impact at the beginning except that it wakes people up, but it gives those that are poor performers an opportunity, and it reduces the political resistance to this because everybody would assume that certainly they can make it by 2008, or whatever, when you're going to reach that threshold that clinically you probably should be at today.

MR. HACKBARTH: Let me connect Bob's comment to what I heard Allen and some others saying about conveying a stronger sense of

urgency.

I think the point is that there is a long history, but we don't have enough progress to show for that long history. That's because there is perhaps constancy in terms of lip service being paid to it, but the level of commitment to action has been, at best, very uneven over the last 20 years, 15 years. So like Bob, I wouldn't want in our --

DR. REISCHAUER: 37 years.

MR. HACKBARTH: 37 years. I wouldn't want our preface acknowledging this long history to be interpreted as oh boy, this has been good stuff all these years. We really don't have what we should have, and we need to step it up and get more results.

MR. MULLER: I share both the sense that the recommendation should express some more urgency. But also, given the various efforts that have passed as efforts towards quality improvement, I would recommend we be a little bit more specific and I think this chapter does a very good job of pointing out some of the things that have worked better than others. I think it's just been too easy to call almost anything anybody does an effort towards quality, which therefore goes to Bob's comment that we kind of pass our hands over the stuff and say it's all quality efforts, and they're really not.

So I think getting more specific based on some of the very successful things that are in the chapter or adding on Mary's QIO, but I think that would help that, given that we spend a lot of time on Medicare, putting our voice and saying some of these initiatives make more sense I think would add some credibility to it.

Everybody else has already said it, so no use beating on these words any more. It's just not urgent enough. And therefore, putting a few e.g.'s in there, I think, would be quite helpful. I'd be glad to recommend which ones they are, but two or three, I think, would be helpful.

DR. NELSON: Balancing off the caveats of the difficulties of physician performance measurement can be some information about the Physician Consortium for Performance Improvement which was convened by the AMA and represents the major specialties that has developed or is developing performance measures for diabetes, coronary disease, heart failure, hypertension osteoarthritis, major depressive disorder, prenatal testing, preventive care and screening for mammograms, influenza, tobacco, colorectal cancer screening, problem drinking, asthma and community-acquired pneumonia.

So a constructive effort to develop the performance measures with the clear implication that there is an acknowledgement of this ultimately being incorporated into physician measurement.

MR. DURENBERGER: I've shared a lot of thoughts with Karen and the staff, and I really am so grateful for the opportunity to be able to do that between meetings. It is really very helpful.

I agree with what Ralph said about, I raised the last time, about PRO, there's a history here. Which leads me to the fact that most of the history was aimed, starting with the prospective payment system, at underused, the danger of underuse. And if we accept underuse, overuse, and misuse as some of our definition, a

lot of our history was sort of guarding against some of the problems when we don't have the right incentives in the payment system.

I went to my first board meeting of NCQA a couple of weeks ago and found out that, next to consumer-driven health care, quality is sort of like the business buzz word, and everybody is getting into it, every specialty association is going to identify it.

Which for me just fortifies what I've heard around the table here today, which is why it's so critical that Medicare set the pace. And that we, in whatever we say to our friends on the Hill, help them set the pace. I won't belabor why but I do want to thank Nancy-Ann, as I've done before, and now Tom Scully, because I think they really have -- to the degree that this has to be acknowledged I'm not sure it's necessarily all that important.

But I really honest to God do believe that the leadership in HCFA and CMS has been trying to deal with this problem. And I don't know that this paper gives them adequate credit for that because it relies heavily on privates do better than publics and so forth. And that isn't always necessarily the case.

Point number two, though, deals with the specifics. The comments in here tend to reflect that it's nice what CMS is doing, but they're not doing the ideal, which would be payment differential. And someone has said this before, that I think to get to a culture of quality you're not going to do it one person at a time. You're going to do it one community of practitioners at a time. And that might be a multi-specialty group or it might be a city or some other community or something like that.

But the notion that somehow or other we're going to get there -- and I'm not saying that in the end payment differentials aren't critical and so forth. If you want to talk about incentives, the best place to go is to go to a group of physicians and/or other health professions. Some kind of an integrated system is always preferable. You can see its there already.

But the concept of culture of quality can be built best by changing the practice. And the best way to change the practice is if the doctors change it themselves because they're getting rewarded for doing it. Rather than having the public or CMS say this doctor gets so many dollars and that one doesn't, which leads to the political problems that Bob talked about last time, doctors themselves discipline the system. They work the changes that take place within the practice.

So I think it's simply the way this is presented. It isn't like pay differentials is better than what Tom Scully's trying to do right now, because I think what he's trying to do right now, as I see it at least, is to take groups like the 200 docs or more group or 200 docs or less group, I don't know what he's doing.

I think he's trying to take these larger groups and provide them with the incentive. Minnesota has an application to take the whole state as a demonstration. The idea is to build the incentives into this community of doctors to change the way we do it and let them keep some of the savings that come from it.

That's the incentives part.

I was hoping, in the way we talk about this, that we don't say that doctor by doctor differentials, insofar as it's implied that language, is preferable to what the CMS is currently working on which is, in the larger groups and so forth, but at least maybe equate them and say whatever you want about the payment differential.

DR. WOLTER: I just want to underscore my belief in the importance of what Dave just said. I think that differentials based on the current payment system is one thing, but changing the way we pay to decrease the fragmentation of the current health care delivery system is the critical transformation that has to happen in the system. It would be nice to be able to talk about that in this chapter.

I think differentials have their place, but we've talked about Part A and Part B. We need to put some things in place that create teams of people delivering care in a important effective manner. The current system really, in many ways, creates barriers to that. That's why I don't really favor highlighting Medicare+Choice, by the way. I think it belongs on the list, and for what I just said I can see why you might choose that as a place to highlight, but I think that if we're going to make headway really, and if this is urgent, we need payment mechanisms that really create bringing people together to deliver care.

If we could get into that, to some degree, in this chapter I think it would be very important.

MR. HACKBARTH: There are some places in the chapter, and perhaps they need to be beefed up or reworded a bit. But I can think of a few places in there that refer to how central that concept is. I agree.

MS. RAPHAEL: I was just going to follow up on that because I think what we're doing is deriving our recommendation from the private sector and what's workable in the private sector. And where we have good measures. Those are sort of the two pillars that we're building our recommendation on.

You could also say part of the criteria should be where are beneficiaries experiencing the most problems in terms of care? I think where beneficiaries experience the most problems is in the lack of continuity between a primary doc and a specialist, the hand-off between the hospital and the place the person is going to afterwards. That's another valid criteria that should determine where you focus your experimentation and efforts.

I agree with what Nick just said. I think we need to think about some experiment that would deal with the continuity index which is in this chapter. The other, I think, really powerful area that we have to deal with is the current disincentives, that if you make an improvement in your domain, in your silo of the world, it could really affect the Medicare program in another silo that doesn't accrue to you. Some of the things you could you could reduce admissions to hospitals so your disincented from doing it.

So I would somehow like to see something, even in a recommendation, that would take us maybe one step beyond this in

experimentation.

MR. HACKBARTH: What's tricky here is that we have two, at least two purposes, in this chapter. One is to present some conceptual thinking about how quality might be improved. And all of the recent discussion I fully agree with. Probably the greatest opportunities are in terms of integrating the care, improving the hand-offs, thinking in terms of teams as opposed to individual providers. I emphasize how strongly I agree with that.

The other purpose though of the chapter is to try to continue to create some momentum so we're looking for what can done in the short run. The trick is to write this in a way so that it's clear to the reader that by endorsing some specific short-term steps -- that's not to say that they are as important or more important than the long run, but we want to create some momentum. Some things need to get done, even while we continue to look for much more important opportunities in the areas just described.

In fact, it may be good early on in the chapter, to about how we have two purposes here. One is to advance the broader, longer-term cause. But second create the sense of urgency to begin moving ahead in the areas with the greatest short-term possibility.

DR. WAKEFIELD: Even the wording of that recommendation, I think Glenn, does not diminish what you just said. I could take that concept and think about this recommendation moving both the long-term issue forward as well as the short-term. So I think they could write this chapter in a way that CMS could see that recommendation and think it could easily apply to both of these issues, a coordinated continuum of care side as well as this more --

MR. HACKBARTH: I can see how Nick or Dave or Carol might be concerned, if we have readers that just look at the bold-faced printed and they look at this, their message is lost. All they see is evaluate provider payment differentials.

MS. MILGATE: What if we said within and across settings? Does that help?

MR. HACKBARTH: I'm not sure, without making the bold-faced print run for a page, that we're going to be able to capture all of the nuances here.

DR. WOLTER: We could say something like payment differentials and mechanisms, to imply that case management or emerging Part A and B or other --

MR. HACKBARTH: What I had thought of was this particular recommendation was a low-hanging fruit recommendation. It was to say there's a whole lot of stuff going on in Medicare demonstrations, in the private sector. Right now we think provider payment differentials are the greatest short-term possibility.

Maybe what we need to do is have a separate recommendation that says, in the longer-term the greater opportunities are not looking at individual providers, but more systematically at the patterns of care and how providers relate to one another.

MR. MULLER: I think that captures what I was trying to say,

which is we've had the effort where M+C hasn't taken off as much as people thought it might, and we still have fee-for-service in the bulk of the program. But as a number of people said, the fee-for-service system really makes some of this coordination very difficult. So I think we need to experiment whether the mechanism word is sufficient. But we also need to experiment with some systems of payment that go beyond fee-for-service, that don't necessarily mean to get everybody back into thinking that the only alternative is M+C. But some systems of payment that promote and encourage innovative care to go forth that enhances quality.

DR. REISCHAUER: This might argue for taking a big chunk of the CABG discussion and putting it in this chapter, because that's exactly what that was.

MS. MILGATE: Sure.

MR. HACKBARTH: We're running out of time here.

MR. DURENBERGER: I know you want to quit.

I think the problem, as I follow this discussion, is that we come very specifically and say Medicare+Choice plans are the place to start. If I took you to InterMountain, I'd take you to Marshfield in Wisconsin, I'd take you to a lot of places like that. I'd start there before I'd start with the Medicare+Choice plans because they've got the data, they've got all the information.

It's the exclusion of existing practitioners who have been leading the way on quality from our recommendations as to where to start that I have a problem with. I don't know how you want to deal with that one, but there are a lot of really good examples in America today, we heard from some of them a few months ago, that ought to be places we start, as well.

MR. HACKBARTH: Let me try to use that comment to really sharpen the issue. InterMountain Health Care, I used to work for InterMountain Health Care. I think great things.

But when you focus on what they're doing, you're not talking about a systemic effect in the program. Whereas, if you take M+C here, albeit it a small piece of the program, you're saying here's something that affects all of this little box within Medicare. It's not an isolated provider demonstration, but moving to implementation of a set of measures that affect a piece of the program.

In fact, in some ways this goes back to our earlier discussion. There's two tracks here. One is program implementation, the other is demonstration. I think there's a lot of important demonstration and research work to do with people like IHC. But right now there's an opportunity to implement something as a part of the program with M+C and inpatient rehab.

One is not better than the other. We need to move on both is the message that I hope will come through. Is that consistent with what you're saying? Or would you rather just drop M+C and do provider-specific demonstrations?

MR. DURENBERGER: No, this is why I said earlier either complementing Medicare rather than saying there's something better than what they're doing, but recognizing in the specific

what CMS is currently doing with provider groups. Adding that to the Medicare+Choice.

I just don't like to see Medicare -- maybe I don't know enough about Medicare+Choice, but we're going to get more in the long run for systemic change by going to Medicare+Choice than we would get by using the current demos along with is, I guess, where I'm at. Not that we're deciding anything anyway.

DR. MILLER: Just a couple quick things.

By way of editorial, I imagine Karen is feeling the same way I am right now, that none of this chapter was intended to somehow imply that what CMS was doing wasn't good. In fact, we had very explicit conversations about putting sentences in that said this is a good thing.

So we must need to pump that up more because it's certainly what we think, and QIO and all the rest of that.

The other thing, and I'll take some responsibility for this if not all, depending on how it plays here. I was trying to push Karen and company to say let's talk about concrete things that they can do, places where we think the infrastructure and the information -- largely because of CMS's efforts -- is already in place and they could quickly move on it.

I don't think any of our views are M+C is the place that you have to go, or any of our views are that you couldn't pick up a group and pull them into these kinds of payment differentials to look either at coordinated care or some of the activities of the groups that you're talking about. We must not have gotten the words quite right because you're not saying anything that's inconsistent with where we're going.

But we didn't want a chapter recommendation that just sort of said oh, you should do more quality stuff. We were trying to say here is the areas that we think have some promise, to point in their direction a little bit.

MR. DURENBERGER: Maybe I was reacting sort of small p politically, with is somebody like AAHP sees that recommendation, it's a source of new money, let's start focusing on Medicare+Choice, takes it away from something else that the administrator believes might have an equal amount of payoff. So it's that sort of instinct that may have misled me.

But as long as we're comprehensive in our recommendation.

MR. MULLER: I'll go back to my e.g. example and what we discussed both in today's whole morning and in prior sessions, some of the things that we think can relate to quality, disease management, case management, bundled payments, and then some of the other examples in here.

So I would like to highlight some of those as things we should experiment with to be more specific about what provider payment differentials and mechanisms mean.

DR. WOLTER: Glenn, I think what we're saying is that maybe there should be just equal billing. Just as one concrete example, in the S/HMOs, the quality results that we're seeing came out of the group practices, not out of the looser network part of the plan.

I just think that there's an infrastructure in place. It's not a longer-term. It could be as short-term as looking at

Medicare+Choice. It's not to take Medicare+Choice off, I don't think it's an either/or at all. It's equal billing.

MR. HACKBARTH: Let me ask you then, Nick, as the last one to speak, to make a specific proposal that you would like the Commission to consider. If we've got one recommendation.

DR. WOLTER: What I would do is just in the text not have Medicare+Choice jump out as the place to start, but to certainly highlight it as a place where good work can be done. But also, we should be looking in this other areas which, as you pointed out, are already in the text and could be moved up a bit.

And then we might slightly modify that recommendation so that it also includes other ways of a payment being put in place to increase coordination of care, differentials and other innovative mechanisms, something that.

MR. HACKBARTH: Are you going to suggest something specific?

DR. NEWHOUSE: I'm going to respond to Nick. The mechanisms didn't do a lot for me when you said it. But I'm wondering if you really mean more aggregated payments or bundled payments or something of that nature. Maybe the text just spells it out. But is that what you mean?

DR. WOLTER: Actually, I mean a long list of things and I know we're running out of time. But it could be more bundled payments. It could be better payment for case management. It could be payment for e-mail care. It could be better payment for using technology to take care patients in their homes.

I mean, we've been given a list by some of the people who came before us in the last few months. There's a lot of innovation in some of these ideas. And I would think we would want the demonstrations to include some of those things.

MS. MILGATE: Just a reaction to that, one of the basic assumptions that we did make -- it doesn't mean that we can't talk about it, and it might be good to set it aside because it sounds like folks are having trouble with that assumption -- was we tried to look to the extent we could at something to build on the current payment system because taking on changing the whole payment system seemed a little bit larger than we wanted to handle, particularly from what we found in the private sector. Although that wasn't our bias in the beginning, I would say.

But I don't think that means that we couldn't discuss that there are many other ways that you could look at changing payment, and here's a list of what those things might be.

DR. WOLTER: I think it's just a bias. I think what some people in this room are saying is maybe it's time to express urgency, to be a little bolder, and to suggest that more out of the box thinking. It's not something we should wait 10 years to get to. That would certainly be my bias.

DR. NEWHOUSE: I think the problem, I'm with Glen on the shorter-term, longer-term thing. The problem is in the shorter term you don't want to put something in nationally that you haven't seen before. The downside is just too big.

So it seems to me that the stuff we haven't much experience with we probably would want to go a demonstration route in the shorter run.

Well that's fine, I think that's the sense then. In the

shorter run we could do M+C and inpatient rehab. And we could do demonstrations elsewhere.

MR. HACKBARTH: And emphasize in the text that the fact that the M+C and inpatient rehab are coming first is not a statement about their importance but rather their ripeness, and that the real gain -- I'm the truest of true believers in terms of what you're saying, Nick. The biggest long-term gain is in these more systematic approaches to integrating care and looking across individual providers.

The text language is obviously, in some ways, the easiest part because it gets it off the table for right now and we can all look at the draft language once it's circulated. The piece that we need to deal with right now is whether we alter this draft recommendation language.

And what I hear is Nick expressing a strong preference to adding some reference to coordinated care in some form in a demonstration mode.

DR. MILLER: Right. For example, on this recommendation, if you were to add words after the payment differential and say something like and other -- you could use the word coordinated care delivery systems or comprehensive care delivery systems -- and just put it in after the word differential. You've got both demonstrations, payment differentials, and that this concept then Nick is talking about. Does that reach it?

MR. HACKBARTH: Say it one more time.

DR. MILLER: It would read just like it does up to payment differentials, and then would say something like and other coordinated care delivery systems that reward and improve quality. It's just putting a clause in after differential and before that.

DR. REISCHAUER: In a way, coordinated care is too narrow.

MR. HACKBARTH: Let me establish a ground rule, when you grab the microphone now, the requirement is that you propose an alternative if you don't like it.

DR. NELSON: I hate to disagree with Nick because I think his concept should be dealt with clearly and firmly in the text. But I think this covers it. This chapter is talking about payment differentials. And I think that this provides latitude for a variety of mechanisms.

So my alternative is to stick with that recommendation.

DR. REISCHAUER: What about saying payment differentials and structures? Because what you're talking about is different payment structures.

MR. MULLER: Those words, by themselves, would not capture this discussion over the last hour. So if the people only read those recommendations, they wouldn't capture what we've spent our time trying to come to some agreement on, which also reflects six months of discussions.

So I would like to add some words that capture -- I like Bob's differential payment and structures and collective mechanisms. I'll work on the words, but I think something along those lines.

MR. HACKBARTH: Do you want to say it one more time, Bob? You're making the motion here.

DR. REISCHAUER: The question was whether I was going to accept the senator from Pennsylvania now.

MR. HACKBARTH: Make a proposal. We need to get this done.

DR. REISCHAUER: Payment differentials, structures and -- Ralph? Differentials, structures, and --

MR. MULLER: Collective care and care coordination.

DR. WAKEFIELD: I have a question about that.

MR. HACKBARTH: Are you going to suggest an alternative?

DR. WAKEFIELD: I'm going to raise a question. I need an interpretation of that. Because what that rephrasing says to me is we have just delinked a payment incentive from structures and collective whatever --

DR. REISCHAUER: You know, I think in a way structures encompasses what you're talking about.

DR. WAKEFIELD: But I'm saying is it we're going to evaluate provider payment differentials, structures, and something else? Or are we using payment incentive to reward and improve quality, and those different models could be different structures, collective whatever organizations we were talking about a minute ago?

All I'm saying is are you delinking the payment driver her and saying it's okay if they evaluate different types of systems of care? And do we want to do that?

I thought we were using the payment differential as the driver and that different models could be put on the table that would be designed to reward, that would be designed to achieve quality improvement. It's in the wording of that that I'm expressing concern.

MR. MULLER: We had the clause in the wrong place. I think we agree that we want payment differentials. What we're trying to capture is that there's some consensus as to the kind of things we should be experimenting with.

MS. ROSENBLATT: How about differentials, structures and models that...

MR. HACKBARTH: Conduct demonstrations to evaluate provider payment.

DR. WOLTER: Glenn, I'm sorry I got us into this mess, honestly. I was actually trying to be very specific to payment. And my original point was differentials is one thing, other models of payment or other structures of payment, not the structures of care, could be part of what we do. So I actually think Bob's recommendation handles it. And we cover the models of care in the chapter.

DR. NEWHOUSE: How about provider payment methods?

DR. REISCHAUER: It sounds too much like it's taking the existing payment structure and you can go up or down, that kind of thing. This is sort of a different --

DR. NEWHOUSE: How about provider payment methods? It gets us out of -- differentials seems narrow.

MR. HACKBARTH: The other alternative here is, rather than trying to cram it into one sentence, we could have two. One would be to do demonstrations to evaluate payment differentials to reward and improve quality. In addition, demonstrations should be done of payment mechanisms that reward better

coordination and integration of care.

MR. SMITH: I think Nick and Mary are right about that. What we want to do is use payment differentials and payment structures to reward improved quality. Those payment differentials or payment structures might provide additional payment for precisely what Nick's talking about.

But we want to make this about the payment system. We don't want to make this about several things. We want to use the payment system to get the kind of structures that produce the kind of quality outcomes that Medicare ought to be aiming for.

So I think if the sentence reads payment differentials and payment structures, or maybe even just payment differentials and structures. So we're talking about payment structures not organizational structures. I think we then capture this conversation.

MR. HACKBARTH: The language on the table is payment differentials and payment structures, or payment differentials and structures that reward and improve quality. All those opposed? If you dare. All those in favor? Abstain?

We're going to modify the agenda here to a bit because of our running over. We are going to take the piece on the CMS letter, on the update for physician services, and move that to after lunch. I am hopeful that that's going to be a very quick item. In fact, it's going to need to be because Kevin needs to leave. So we'll do that after lunch.

Before we leave for lunch, we need to vote on our revised S/HMO recommendation. While I'm thinking of it, before we turn to the recommendation, just so I don't forget -- oh, this really is just logistics. We're going to have lunch in a different room. We'll handle that once we adjourn.

Let's go to the S/HMO recommendation. Do you have anything you want to say, Tim or Scott?

MR. GREENE: This is a modification of the recommendation you saw earlier. We address Joe's concern about the frailty adjustment modeling and proposal that was built into the previous one.

Here we simply phase out the 5.3 percent S/HMO add-on on the same schedule that CMS is using, the statutory schedule for implementing risk-adjustment in the Medicare+Choice program.

MR. HACKBARTH: Unstated here is that concurrently we phase in the risk adjustment for the S/HMOs just as it's being phased in for all of the other M+C plans.

MR. GREENE: I'll show you. This would be the schedule and this is the existing schedule, M+C schedule. In the first year 2004, 70 percent of the 5.3 percent would represent 70 percent of payment and risk adjustment 30 percent. The 5.3 percent add-on is reduced to 50 percent the next year. And by 2007 these plans would be treated as other M+C plans would be, they'd be paid under M+C risk adjustment, without any frailty add-on or any such factor.

MR. MULLER: We still have recommendation two, or was this meant to absorb two?

DR. HARRISON: You would also have two.

DR. NEWHOUSE: Two encourages research on frailty.

MR. HACKBARTH: Rather than having you try to flip back and forth, just leave the one up. People can look at the packet that they have in front of them for the language of number two. Just put up your alternative one.

All opposed to the revised alternative? All in favor? Abstain?

And then number two in the packet, has everybody found that?

All opposed to recommendation two? All in favor? Abstain?

Do you need another minute?

MS. DePARLE: I'm sorry, I found it. I would like to vote in favor of that.

MR. HACKBARTH: Let's just, for the record, do that vote one more time. Has everybody seen it now, recommendation two?

All opposed? All in favor? Abstain?

Okay. I think we're done. Thank you