MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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10:11 a.m.

COMMISSIONERS PRESENT:

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MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Bundled payments for physician services
-- Kevin Hayes, Vivek Garg

MR. HACKBARTH: Okay, let's turn to our agenda for this afternoon. The first issue is physician payment and specifically bundled payment options. Kevin?

DR. HAYES: Good afternoon. Our plans for the June report include a chapter on use of physician services, and one topic we could consider as part of that chapter is bundled payment for physician services. So we're here today to provide you with an overview as to why the Commission might want to see that topic addressed in the June report and how we would address questions on the topic for a chapter in the report.

When they say bundling, we're referring to the size of the unit of payment. For physician services the unit of payment is small. It's one of 7,000 discrete services for which there are payment rates in Medicare's physician fee schedule. The question is whether that unit of payment should be expanded in some way.

There are two general approaches to doing something like this. The first would be to group related services that are provided to patients offer a span of time. An example of this comes from the current somewhat limited bundling that is in thfee schedule already and that would be for surgical services where we see a single payment rate for pre-op visits, the surgical procedure itself, and post-op visits.

Another approach to bundling is to group services that are provided together at a point in time. An example of that would come from the way Medicare pays rural health clinics. There is a single per-visit rate that is paid and it covers the visit itself as well as related ancillary services such as lab work.

So we're ready to move on to the topics at hand. Before I do so just let me point out that in the paper that we sent you for this meeting you saw that we made use of some software that groups claims into episodes of care. Vivek ran the software and he's here with me today so if you have any questions about that you can address them to him.

So as we look more closely at this topic we know that there is some bundling of payments already in the fee schedule. I cited the surgical services example. Another example is the monthly capitation rate that physicians receive for the services they provide in the way of evaluation and management of dialysis patients. What are the other possibilities? At this point it's hard to say where we would end up, but what's left is non-surgical services as well as surgical services and associated non-surgical services provided during the same episode of care but not currently part of the surgical bundle at present.

Reasons to consider further bundling, we've listed three here. The first is that it would broaden the scope of financial incentives for efficiency. Second, it seems that from an administrative feasibility standpoint it's a bit more feasible now to do more bundling than it was in the 1980s when bundling

was last considered as an issue. And the third possibility is that it would seem, just on the surface anyway, that it would be easier to link payment to measures of quality of care. This is a topic that you addressed in this past June's report. So what we'll do now is just go through these reasons here one by one.

Focusing first on bundling and financial incentives, recall that the Commission over the years has spent a fair amount of time considering the major design elements of payment systems and one of those is the unit of payment. With a large unit of payment, the scope of financial incentives includes both the mix and quantity of services and the inputs used to provide services. In the case of a small unit of payment like that in the physician fee schedule, the scope of the incentives is more narrow. It just applies to the inputs used in delivery of services.

So the question here is whether it's time to revisit the fee schedule, the physician fee schedule's unit of payment? One reason to do that follows up on the discussion you had last month. We had a panel made up of Elliott Fisher and David Cutler and there was some discussion there about overuse of services. So reconsidering the unit of payment in the fee schedule might be one way to address that problem.

A disadvantage of bundling, however, is that it does increase the risk of stinting. So the question then would be, in any consideration of this, whether it's possible to minimize that risk as part of any expanded bundling policy.

Moving on to the next item here which would be the question about whether it's administratively feasible to do this. Here, just as I said, it seems like it's a bit more feasible from an administrative standpoint to do bundling now than it was previously. To bundle services two things need to happen. One is it's necessary to decide what services are in the bundle and when they're bundled. In other words, how the bundles are defined. The other consideration is just that it's necessary to identify these bundles during claims processing.

Looking at these two points separately we can see on the issue of just defining the bundles we have seen the emergence of the availability over the past ten years or so of the software to bundle claims into episodes of care. So that would be one tool that could be used to help figure out how to define bundles.

The other is that there is precedent now for clinical involvement in matters of this sort. CMS and its contractors currently use coding edits to review the billing codes that are reported on claims for payment. As part of that process there is input from a group known as the correct coding policy committee which is made up of physicians and other health care professionals. So a question here would be whether that process for working on the coding edits could be adapted to consider the bundling of the type that we're discussing here today.

On this issue, I mentioned the coding edits, it would seem like a tool of that sort would be an integral part of implementing any expanded bundling policy. Those edits are in place now used by CMS's contractors who process the claims. It would be a matter of invoking those edits and making payments accordingly.

A third reason to consider bundling has to do with this idea of linking quality measures and payment. Currently the payments for physician services are for services, for discrete services. By contrast, when we consider the research that's going on on development of quality measures, the focus there is somewhat on services but it's primarily on conditions. You could see that this morning in the discussion about disease management, that that seems to be a hot bed of activity. But on development of quality measures, thereto, it seems like the focus is on conditions.

When we take, for example, the work of the Agency for Healthcare Research and Quality, they have set up these evidence-based practice centers to prepare reports, conduct technology assessments and so on on care for Medicare and Medicaid beneficiaries. If you look at the topics that those centers are working on it's either overall care for patients with certain conditions or it's services but services always in the context of conditions.

So connecting all this idea to bundling, with bundling, there again we're talking about payments for services, but like AHRQ's work it's in the context of conditions. So if that's the case it would seem that it would be possible to link quality measures to bundles according to the conditions that are used to defined them.

So what would we do on this topic for the June report? If we think about bundling and the related concept of episodes of care and where the innovation is these days, some of it is in the private sector in the areas of disease management, provider profiling, and payment. So one thing we would do is to consult with private sector experts who have experience in these areas and develop an understanding of the strengths and weaknesses of bundling. We would also review the experience with bundling in Medicare. CMS staff have been thinking about this topic for a long time and we would meet with them and get their thoughts on what might work. We'd also review the experience with the centers of excellence demonstrations for lessons learned.

The next issue we would need to address would be identifying alternative criteria for defining the payment bundles. An example of such a criterion would be something having to do with the number of physicians involved and whether it would be necessary to define bundles in terms of just the services that are typically provided by just one physician or whether it needs to be something perhaps larger.

Another issue concerns determining payment amounts for bundles. This ground was covered when decisions were made about the bundled payments for surgical services, so we would review that experience and we would also draw on any relevant experience in the private sector.

Another topic to consider here has that to do with those coding edits and the extent to which they could be used in an expanded bundling policy. There we would consult with CMS staff and the claims processing contractors that they use. We would also talk to representatives of the AMA's correct coding policy committee.

With respect to quality measures that might be relevant here, we would conduct a literature review and identify evidence-based measures of quality that are relevant to different types of episodes of care and therefore to different payment bundles.

Finally, we would assess options for minimizing the risk of stinting.

So that's about all we wanted to cover here. We're anxious to get your feedback on how to proceed on this topic, and happy to answer any questions that you have.

DR. NEWHOUSE: Kevin, it was hard for me to get my hands around this at this level of generality but I think if we can talk about specific cases where it might be useful we'll be ahead. But let me say I'm generally kind of skeptical about how much gold is in the ore here. We know we have a problem of overuse and underuse. You actually allude to that. At first blush, as you say, this reduces overuse but at the price potentially of increasing underuse. You talk about a couple of thinks that I wanted to ask you about in that context.

One is, as I understood it, you were going to make the fee dependent on certain things happening. This was the tie to quality-based payment. It wasn't clear to me that we needed to bundle to do that, if we were going to do that. And if we were going to do that, whether or not it's in the context of bundling there's a lot of issues to be addressed like how do you update this. This sounds a little like the FASB updating accounting standards to me. And how do you audited if this was actually done. If it's on the outcome side then we get into the whole risk adjustment issue.

Then the episode issue almost surely would often involve multiple physicians. Then I'm not clear who gets the bundled payment. We don't even, for a lot of reasons don't bundle, for example, surgeons and anesthesiologists payment which clearly would be one of the most obvious things to bundle if you were going to go this route. So I'm not sure what you have in mind when you say, bundle an episode unless it's entirely within the purview of one physician.

DR. HAYES: Let me take a stab at those. With respect to the link between payment and quality, I could see an evaluation, so to speak, of policy in this area where we start out just identifying payment bundles based on criteria that we've alluded to in the general way in this. Whatever those payment bundles are, fine. Then in keeping with the Commission's recommendation about using incentives to reward quality, I could see where on a parallel track, whatever the case might be, that there would be a move also to try and link measures of quality with the payments.

One of the things that we would want to do is to do some research to identify the extent to which there are evidence-based measures of quality that could be used for this purpose. At this point we don't do what the state of play is in that area. I'm optimistic that there are going to be some evidence-based measures of quality that would be useful for this purpose. But in any case, I see some linkage here between a bundling policy and linking quality measures to the bundled payments, but there are some timing issues that would have to be sorted out and it

could be that one would happen before the other.

On the other business about multiple physicians, you're exactly right. It all turns on this question of how the bundles are defined, and to what extent we can identify bundles that are typically provided by one physician. Let's say that there's a decision made that we want to focus only on bundles where usually services are provided by one physician. Then we would look at the claims data and see to what extent it's possible to identify bundles of that sort, how meaningful they would be in the grand scheme of things in terms of spending, to what extent they respond to other criteria that might be relevant.

There could be, I could imagine, a branching here where you say, okay, we're going to focus on episodes that are typically provided by one physician but we need to have some provision in this policy that allows for cases where multiple physicians happen to be involved. That is true with respect to the current bundling for surgical services where it is possible for physicians to provide within a surgical bundle just the pre-op visits, just the post-op visit, and a different physician provides a surgical procedures itself. So in the claims processing there are these payment modifiers that are identified on claims that flag such claims.

So that's the kind of thing that would get sorted out as we work through this, and I see some do-ability here but without going further we don't know exactly what things would look like.

MR. HACKBARTH: Let me just say a word about the context for this discussion, at least as I see it. This presentation is part of a series now that goes back over quite some period of time. We have looked at physician payment issues. We're on record as being unhappy with the SGR as a way of dealing with, if not the actual increase in volume and intensity, the risk that the rate of increase in volume and intensity will grow over time. Medicare more recently has been in a period where the growth in volume and intensity has been relatively low, though in the last year, 18 months there's been now again some uptick in the rate of increase.

I have found myself in the position, in dealing with people on the Hill, of being asked the question, if you don't like SGR, what do you like? We could respond to that by saying, we are simply not concerned about what's happening in volume and intensity, or we can look for alternative approaches that we think would be for compatible with--

DR. NEWHOUSE: I thought we said we'd like something similar to what institutional providers, the process for setting their update, as opposed to a mechanical formula.

MR. HACKBARTH: In fact we did. What we said was that the initial baseline was to use a measure of input price increase with a productivity adjustment, but then there's also a discretionary factor. But even there you would be manipulating a price to deal with the volume issue and there are other ways that you can go, including bundling to create incentives for controlling volume.

So the implicit premise of this presentation, I think, is that there is some concern, if not about the current growth in

volume and intensity, the potential that it will accelerate and pose significant budgetary problems for the program. Maybe before running down that path we need to have some explicit discussion among the commissioners about how concerned we are about that, whether we believe that we need to come up with a proposal to deal with volume and intensity, or alternatively, we think that for the most part the growth in volume and intensity is a good thing. It's better care for Medicare beneficiaries.

MS. BURKE: Glenn, it seems to me that the other issue that's there but unsaid and is picked up a little bit in the document but I think needs to brought out as well, is the extent to which the payment system moves towards a system where there is a check on quality, where there is a presumption that we can move towards a series of decisions that encourage certain kinds of care. One the questions in bundling that I found here but not here is this question, because there's a presumption that you can't link metrics to individual services but only into bundles and I'm not entirely sure I agree with that, which was Joe's point as well.

But it seems to me that in addition to your question of, do we believe there's a concern about intensity and about volume is also the implicit question about whether or not what we're seeing is in fact linked to quality, and whether in fact is down result in outcomes that are what they ought to be. So I think as we engage that question we need to look at it in the broader context as well. That it ought to be, to what extent can you build a system that presumes to have some linkage to an outcome that is measurable and is related to quality ought to be part of that fundamental question as well.

DR. NEWHOUSE: Glenn, can I respond to you? The evidence on overuse, and underuse for that matter, is in the cross-section. It's the Miami's of the world. That's a very different issue than the growth over time which is going on everywhere and which may well relate to what beneficiaries ought to be getting. It seems to me very hard to use payment policy that's going to address an overuse and not potentially also affect underuse. But that's all in the cross-section. I just see the issue of the SGR and control on volume growth over time as a very different issue than the issue of overuse and underuse at a point in time.

DR. NELSON: We know that there are variations, but we don't know where within that variation the optimal lies. One of the problems that I had with the tone of this paper in talking about incentives to reduce overuse was the fact that it seems to me that if we decide to look at bundling it ought to be to try and link payment with the appropriate use, and that if there are all of these unrecognized or undertreated hypertensives wandering around out there, we've said that preventive services aren't being offered at the rate that they should, we say that diabetes is not being managed to the degree that it really should be, that indeed there may be a greater potential for--that is, the underuse problem may be a bigger problem than the overuse problem. It may turn out to be a wash.

What we want to aim for, if bundling has any capacity to do, and I doubt that it does, if we're talking by and large about E&M

services, and that's mostly what we're talking about here, it might be possible to bundle EKGs into office visits or something like that, but trying to bundle E&M services in a way to rationalize usage it seems to me is a tough call because we don't know where the optimal lies. We know there are big differences in how often people with chronic conditions see doctors, but we don't know how often they should.

DR. NEWHOUSE: And even if we had the right rate, you've got to get it to the right people. You could have exactly the right rate and if the wrong people get it, you haven't accomplish anything.

DR. ROWE: A couple points. I agree with much of what's been said. First, you've talked in the paper and your comments about consulting the AMA's correct coding policy committee and I think that's a good thing. The AMA has a view about correct coding and it's not necessarily the only view out there.

You also mentioned consulting with some of the software vendors that CMS has begun to deal with and I'd just point out that this is an issue that health plans have been dealing with for 15 years. This is a very high volume issue for us. My company handles about 800,000 claims a day and we have a vast experience with the question of bundling, in courtrooms as well as out of courtrooms. I think you might consider talking with some health plans, private sector experts, and you might get a group of them that have particularly done some M+C work so that they have some understanding about Medicare as well and get an intersection there.

Secondly, I'm concerned about some of the adverse effects of bundling, unintended adverse effects. Clinically, I think the issue of reducing the use of preventive services is a very, very significant concern. We have to make sure that preventive services are not further reduce in their utilization. We just need, to whatever extent there needs to be some juice in the payment system to make sure that preventive services are made available to every Medicare beneficiary, we need not to--make sure that we remove that or dilute in some way. I think that's a significant concern.

I think it would be helpful to frame this as it's not just about the money. The discussion is about overuse and cost-effectiveness, but the facts are that if a patient goes into a doctor and has an interaction with a physician that generate five claims, that's five claims that have to be sent in, and five claims that have to be adjudicated, and five checks that have to get sent. It's a very costly experience for the doctor's office and for whoever is cutting the check. Even if the total amount of money was exactly the same that the doctor was getting.

Bundling isn't necessarily just about--it's about making the system much more efficient rather than having necessarily any effect on what the doctor does. The implication of the way it's written is that doctors are doing things they don't need to do because they're getting paid for all of them. My point is, if they were just doing exactly what they should do, which many do, sending one bill rather than five bills makes a lot of sense. So I would like to see some language about that.

Let me give you a couple examples of unintended consequences of bundling that you have to be careful about. One is a disaggregation of the bundle in time, so that the patient, instead of going in, explaining to the patient what's going to happen, signing the consent form and having the procedure is you come in on day one, you have the explanation, you sign it, you go home, you think about it overnight, you come back the second day and you have the procedure, so you have two visits. Because if you did it all at once it would be one visit and you'd only get paid for the procedure and you don't get paid for any of the extra time that it takes, et cetera. So that's not an efficient system that works that way.

A second is a disaggregation of the services not in time but by person. You wind up involving more providers than you need to provide because if one provider did it all it would be one bundle, one bill. But if I do X and he does Y, then there's two bills. So there are these unintended consequences sometimes that we have a lot of experience with and you can think about how to get things done efficiently.

The last point has to do with disease management. Somebody mentioned disease management. I think I want to mention that particularly because I put it in the same category as preventive services, although sometimes it's not considered preventive services but it really is, like eye exams for diabetics, or screening for urine protein and stuff like that. These are really important things and they should get paid for, and if we don't pay for them they're not going to get done as often as they are if we do pay for them. They've been shown to be cost-effective things to do. So if in bundling we wind up removing payments for things which are in fact cost-effective things to do, it's counterintuitive. So we have to take all these things into consideration as we formulate the bundling.

The last is, I would emphasize a little more the really long term excellent experience we've had with surgery and with comprehensive care in patients on dialysis, because this is not new to Medicare. This has been going on for a very long period of time and it works, I think, for the patients and for the providers. It's mentioned in your paper but I think I'd talk a little more about the duration that we've been doing this and how well it's gone. Thank you.

DR. MILLER: Can I just try and get one clarification in your comments? You preface your comments by saying that you agreed with a lot of what was said, but some of what you were saying seemed to imply that there was bundling that went on among the programs that you deal with. I think even your last comment--

DR. ROWE: Sure.

DR. MILLER: So can you talk, if there's this much concern about it and all of these concerns have been raised, how does it work and what problems or what successes did you have with it?

DR. ROWE: The major problem I think we had as an industry which varied across plans was that in the eyes of many physicians bundling became synonymous with the concept of automatic downcoding, so that it was just seen as a way of paying less.

The views of plans early on was that this unbundling--I remember when I was in academics we used to talk about the concept of the least publishable unit. Instead of having some big paper with a lot of data in it, there were 10 papers that were published. As soon as you got enough data to send this one off to the journal, then you get the next one. The health plan had a view that this was the least billable unit.

So to give an extreme example, instead of a physical it was examination of the left hand, of the left arm, of the left leg, of the left foot, of the back, stuff like that. That is an absurd example but that's the theoretical objection.

I think we've come a long way from there and I think we have a lot of experience with physicians and with health plans in figuring out what kind of bundling makes since clinically and what kind doesn't make sense clinically. I in general feel that the efficiencies that are raised out it are more important than the fraud and abuse aspect of it. I think we're overemphasizing the fraud and abuse aspect of it in the conversation and not emphasizing the efficiency aspect of it. That's my general feeling about it.

MS. DePARLE: So Jack, to Mark's question, do you now pay physicians for office visits in a bundled way as opposed to paying them for individual.

DR. ROWE: I think it varies for what kinds of services there are, what kind of specialties there are, what kinds of diagnosis there are. I'm not an expert on all of these things but there has been worked out approaches to doing it.

MS. BURKE: But Jack, it would seem to me that the obvious place to begin that is with chronic conditions where there's a certain predictability about the things that need to be done over a timeframe. Harder to understand--it's improved by the movement to hospitalists which we're beginning to see where you do have these segmentations where they go in the door and they stop. You have the stuff that happens before, the stuff that happens, and the stuff that happens after in fairly predictable pieces, a surgical piece being the obvious.

But on the non-surgical piece, to what extent have you in fact been able to construct a model that allows you to predict and pay on the basis of things that should occur over the long term in the treatment of someone who--I mean, on the episodic, I walk in the door, I have an acute condition and I move out; different issue. But in the obvious question of the chronically ill which is what you'd likely see in Medicare, beyond the diabetics, the hypertensives, how far have you been able to go in that kind of predictive financing, in structuring those kinds of models?

DR. ROWE: My sense of it is that there's a lot of variability in the industry in how far we've been able to go, and I can't give you exact information on this, Sheila, unfortunately, though when we next meet I'll be prepared to do that and I'd be happy to get my staff in touch with you. But my sense of it is that working with professional groups such as the American College of Obstetrics and Gynecology we've been able to--I'm not familiar with the gynecological oncologist, for

instance. They came to us with a proposal for what they thought was a good bundle, because they said, it doesn't make sense the way you're paying, and it doesn't make sense the way some people are practicing. So by the way we, the gynecological oncologists, believe that this is the correct bundle that should get done for everybody who has X or Y. So it's a disease-specific thing but it's done with the medical professionals obviously.

MS. BURKE: I hear what you're saying. That is a good example of a specific diagnosis that is somewhat predictable in the treatment. You have a certain presenting diagnosis. There are certain things that one does that are--

DR. ROWE: They're going to have a biopsy, and they're going to have this treatment, they're going to have that, and let's just pay for the management of this patient with this problem.

MS. BURKE: Which again suggests defined units lend themselves to this, or specific chronic conditions might lend themselves to this, or other things--it is closer to surgery in that sense. It's fairly definable, beginning, middle, and an end, or a long term.

DR. MILLER: I think that somehow we've gotten--I think it's fair--this is the kind of stuff that we're talking about. When we said non-surgical, maybe it wasn't clear that non-surgery can mean a non-surgical admission; might have a clear path of visits that follows it, to follow up on that. So that might be--like a surgical stay in a hospital has a follow-up bundle of visits, you could move that concept to non-surgery. Not non-surgery in the sense of everything on the planet. I think it's more of the notion of a non-surgical admission, and then precisely the exchange between you two on the notion of a bundled payment for ESRD physicians happens now, or for dialysis happens now. But you could expand that concept to other chronic conditions. This is the kind of stuff--it's not coming across. This is the kind of stuff that was in our mind.

DR. NELSON: The classic example, the one that's talked about in medicine is treatment of a myocardial infarction, where there are a certain number of procedures, there's a protocol that should be followed, and if it's uncomplicated, fairly stereotype length of stay. But there are others that--that stands out because it's one that is so well defined.

But it would really be helpful if--we may not be able to, not having a November meeting, but it would really be helpful to have the kind of panel that we had this morning for disease management with private sector models and programs so we could really drill down on that.

DR. ROWE: We already bundle, the other place we bundle, Mark, that's worth mentioning maybe is in hospital payments. We don't get a bill from the hospital that says, seen by the nurse at 7:30 in the morning; given breakfast. Seen by the physical therapist; transported to X. We get a bill per diem or something, or we pay based on a DRG or something. That's a bundled payment, right?

MS. BURKE: But Jack, we did, in the old days when we moved from 223 limits to--when we made this progression into a DRG system, the work that went into creating those structured

episodes, the DRGs, arguably what we're suggesting here is a comparable kind of analysis on the physician side. The difficulty has always been, I think, is that to the extent that things happen in a building they are more easily defined. That's been our long term problem is, how do you define things that occur outside and all of the players that get involved. The episode in a hospital is a somewhat easily, record kept kind of. But the doc piece has never really been there. The doc piece is arguably a somewhat separate piece.

But I don't disagree with you that's where you'd want to go, but once you move beyond certain predictable, myocardial infarct, certain predictable kinds of things, it does get more complicated. You can imagine for diabetes the things that ought to happen in the treatment of a diabetic patient, how often they ought to be brought in, what are the tests that ought to be done on a routine basis, whether they get their eye exams, whether they get their feet examined, those kinds of things. But my guess is there is a limit to those kinds of things, although maybe as we look at the pattern of use in Medicare they will be a fairly defined set that drive a lot of it that would be worth looking at.

DR. REISCHAUER: You also have to ask whether they're more likely to occur if you bill them separately or if you bundle them.

DR. ROWE: That's the point.

DR. REISCHAUER: And if you bundle them without any kind of qualitative oversight on this--

DR. ROWE: I'm worried about that too, but you have to trust the doctors at some point. I think that while there may be some stinting of services, I guess one of my points is, when we do the analysis we should also include in the analysis the savings associated with reducing the number of claims that are submitted.

DR. REISCHAUER: That's why I asked to butt in because I thought you gave both sides of the argument here, because I was with you when I read this the other day on, save a lot of administrative costs because you don't have to send in a whole lot of bills. But at the same time you have to remember that each of the services that we bundle together almost assuredly would be also separately billable under other kinds of conditions. You raise the possibility that rather than have the lab test done by the doctor he'd say, go to my brother down the hall who's running Joe's lab, or something like that. So you'd have to have a whole lot of checks to make sure that you weren't being ripped off in some sense and there would be a back and forth. So the doc would only have to send in one rather than five bills, but he'd get four letters saying, are you sure this isn't part of the episode, did you order this test, or something like that. That might be more onerous in fact.

DR. ROWE: We have all this experience so you can walk around and talk with some folks and they can tell you what specialties and what diseases are most amenable, what conditions, to an approach. You don't have to do everything. We could add a couple to the dialysis and see how it went.

MR. HACKBARTH: We have a number of people who have been

waiting patiently.

MS. DePARLE: I just had a small point. I think, like most people have said, the idea of determining an episode of care is very appealing and it certainly has worked well in some other context. But my question mainly had to do with your suggestion that this was administratively feasible. I think the way you said it was, should be more administratively feasible than it was 20 years ago. One would hope so, and yet when you bring up the correct coding initiative, about which I know quite a bit, I'm a little bit surprised or curious that that would be seen as a building block for this, because it's a pretty primitive tool. To go back to Jack's vernacular, it was Medicare's attempt to make sure that if someone said they did surgery on your hand, they didn't also bill for amputating your hand. It's pretty basic stuff. It was just coding edits.

And the reason there's an AMA committee is because the AMA didn't like what they thought was black box medicine. They wanted to know what the coding edit were. But CMS, then HCFA, couldn't give them the coding edits because we had, at the strong urging of Congress, purchased some off-the-shelf software to do the edits and that company said they were proprietary so we couldn't give them to the AMA. So that's why all that happened. I'm sure it's a very good group of about clinicians who would be helpful in this process, but I don't think the correct coding initiative, unless it's really become a lot more ambitious than it was a couple years ago is a place to say that we have a building block here.

DR. STOWERS: I just wanted to get back to what Glenn said a minute ago about what we're trying to of accomplish here. I agree with the comments on the tone about stemming or looking at the growth in physician services. But I think when we go back to our chapter on growth in physician services, it's not in E&M, and it's not in following diabetic patients, and it's not in all of the examples that we've been using. It's in the high tech, and all of these kind of things, and yet we're trying to create this tremendously complicated system of bundling in an area that's even had some negative growth in a lot of cases. It may be 1 or 2 percent. So I'm really wondering where we're headed here with that.

And most of those areas that we're talking about, it's more of an underuse problem, if we're going to focus this on quality, instead of an overuse. If we get into looking at these high-end services, then we really get into somebody in the emergency room has ordered the MRI and now how are you going to penalize that physician for ordering an MRI that's going to increase--

So I just really think we're headed up the wrong tree here if we're looking at growth in physician services, or at the very least we link our examples in the bundles that we're looking to to the areas where there are rapid growth in physician services. That even gets back to the drug issue that is penned into that growth rate. So are we going to bundle medications in there too, because that's a huge part of it. So I'm really worried more about the underuse problem than I am the other.

Then I just had another question. I've never read anything

that the bundling with surgery, after all of this 20 years of experience, has slowed growth in spending. I think if we're going to--

DR. ROWE: We don't know what it would have been without it.

DR. STOWERS: But the only thing, there again, to be limited was essentially the number of E&M visits that were connected to the surgery to be sure that we didn't have five post-op visits instead of the four. Again, E&M is not the problem. I'm like you, Jack, I've watched the pre-consult to get them ready for surgery, be sure that it happens X number of days ahead of the surgery, so what normally could have been, arrive that day, get it done kind of thing ends up in a $200 consult three days before surgery. I think it's increased cost and I don't think it's done a thing for the volume of the number of surgeries being done.

So again, I think we really need to connect it to where the growth is, and number two, show that what we've had as a trial over all this period of time has made a difference. So anyway, I'm just a little concerned about where we're headed with E&M visits.

MR. SMITH: Most of what I wanted to raise has been raised several times so I'll try to be brief.

I was struck it looking at the product of the software that you used that it would be easier to link quality measures to the payment system in and unbundled system than a bundled system, and that making sure we understand how we use the quality data, quality information that is now becoming more available, as you point out in here. In an unbundled system it's harder to tell whether it happened or not. So if we want to use the payment system and link it up with quality, I'm not sure why bundling helps.

DR. ROWE: That assumes a fidelity between the billing and what happened. You're assuming that everything that is billed for--

MR. SMITH: That is presented for payment actually happened; right. But that's a different kind of problem. The information and the construction of the episode that the software allows you to do, does allow you to tell whether or not a request for payment was presented for something that should have been done. In a bundled world that's a harder to do.

DR. ROWE: There's a difference between quality of care and quality of billing.

MR. SMITH: I understand.

My second set of questions, Kevin, I'll try to reference them, really had to do with the link between this morning's conversation and this one. It struck me that what was missing from here was an effort to inquire as to whether or not bundling might help us address exactly the questions Jack raised a few minutes ago. That an episode of care bundle or a bundle that incorporated examination, evaluation and preventive services might not be an important addition to the payment system, and how could we think about that bundle?

I think as several of my colleagues have said, the focus here is on bundling as a way to get docs to do less. As a proposition, I'm not at all sure that that's the one we ought to

be embracing. I do think there's a way to think about bundling as getting docs to do more of the right thing. But that's a larger modification of the payment system than a bundle that is aimed at somehow responding to a perception that docs are doing too much, which I think in some cases may be true but I'm not sure a bundle is the right way at it.

MR. MULLER: My comment builds on both Ray's and Dave's, which is what are we trying to bundle? It goes back to the larger unit question, what's the larger unit you want to bundle? We all know that the driver, in many ways, of health care costs, medical costs, is physician initiation. But the actual things we pay for tend not to be the physician services. It's hospitals, it's imaging, et cetera, and so forth, whether it's facilities or devices and so on.

So the question I would raise is, the bundle that one wants if one is looking at both utilization and cost, is the bundle in that interaction between the physician judgment and the device or the facility used. So whether that's an extension of the APC thinking and so forth--so my question and my comment is, do we want to bundle them more in that way, that gives us an incentive to have the physician use the right technology, the right facility, the right drug, the right device and so forth? The discussion so far has been very much on how one thinks about putting together discrete physician services so that you have three visits, or four, or five. But I would say it's the interaction of the doctor with the physical thing that Pete likes so much that we have to think about in terms of the facilities, the drugs, devices, and so forth. That's the larger unit that I would suggest we look at.

DR. NEWHOUSE: This all leads me to wonder how much effort should go into this for the June report. If we come down to we're trying to find instances where it's sensible to bundle that are confined to within single-doctor services, I'm not persuaded that there's a lot of value there, but I could be wrong. I certainly don't think there's enough value that it responds to the concerns, as Glenn framed it, that are raised around the SGR that more bundling somehow relieves the pressure on physician spending.

I want to close with a couple comments on the stinting issue. One is just an example of how pervasive I think it is. In effect, coordination and counseling are bundled with the visit fee in the sense that there's no separate payment for them. I think we all think that those are probably under-provided, and certainly when you talk to physicians they will tell you they don't take the time to tell smokers to stop because they don't get paid for that, and they don't get paid for coordinating the care to any greater degree, and in effect that's a bundled payment.

Now I agree with the comments about the ESRD system but in the ESRD system we have gradually moved so where we have, compared to much of the rest of the system, some reasonable outcome indicators. We have things like KT over V that we monitor and act upon, I think, if they're unsatisfactory. Again, given the concerns about potential underprovision, it's not clear

to me we want to go the route of more bundling without something analogous to that, which I think for much of what we're talking about we're not likely to have.

So again I would be happy to be proved wrong but I'm not sure we're the group, or the staff is the group that ought to work on bundling. People have been thinking about coding for a long time in terms of what CPT codes makes sense to be put together. Are we going to really add to do? Maybe we are, but I think that's where we're at.

DR. NELSON: What's KT over V?

DR. NEWHOUSE: We should ask the nephrologist.

DR. ROWE: It's a measure of dialysis effectiveness. It's essentially a clearance rate kind of measure. It's a blood test.

DR. MILLER: Glenn and I were talking and he wanted me to wrap up and summarize what we're heard. I think all that went really well.

[Laughter.].

DR. MILLER: Actually, I've heard a couple of things to perhaps run to ground, and also to give Kevin credit where credit is due. Kevin has been saying that he wants to bring a panel in in December to talk about how this works and I told him that I wouldn't promise him that because I didn't know how much work we would have to grind through in the December meeting. So credit where credit is due, he had that idea and has been pushing me to make sure that it happens in December and I just wasn't sure we would have the time to do it. The certainly will look for that time a lot more aggressively now.

I also heard two things that are hard to reconcile. Remember, we did talk about technology and growth and some of this flowed from the last conversation we had where some things were taken off of the table and it was, see how far you could get on this. Notionally, if you listen to Jack and some other comments, the notion of bundling for limited circumstances, perhaps for efficiency--and we really weren't trying to convey the tone of fraud and abuse--but efficiency and administrative savings that might be a path, although fully acknowledging that it's not going to capture large blocks of dollars. I don't think we thought that this was going to capture large blocks of dollars either.

A little more complicated is the other comment, drawing together Ralph and Ray's comment, the notion of can you put something together with the physician and the piece of technology that gives an incentive to use the right piece of technology, if I'm following those comments. The notion of trying to focus, Ray, your comment, on where the growth is occurring; high tech imaging and those kinds, and then I think it was Ralph's point on putting together something with the physician and the technology, if I followed your point. We could try and look at that a little bit.

I think those would be the three blocks of things from this I could hear that we could take another look at based on what I heard. I guess the thing I would just draw your attention back to, and maybe this is what the panel would be about, this does go on. People do do this. It's just, I think, a question of what

its intent is and what its purpose is. I really think it does create the building blocks to move towards a quality measurement. I think it is, and I must be crazy but I think it is difficult to track it service by service. It's true that in ESRD you do have all of those measures, but you also have an event that you can track and look at quality relative--

DR. REISCHAUER: No, just the opposite.

DR. MILLER: Like I said, I must be crazy.

MR. HACKBARTH: What I hear Mark saying is, it's not just the bundling in and of itself. It's a way of thinking about the care that needs to be provided. It's not discrete visits. So the idea is, you bundle these things together and say, for this particular condition you need kind of a course of treatment. It's not enough that you pay on that basis alone. You also have to have the quality measures and assess what happens.

DR. REISCHAUER: But you have at least the claim that the service was delivered when you keep things unbundled.

DR. NEWHOUSE: Under penalty of law.

DR. REISCHAUER: So why is this an advance?

MS. DePARLE: You could say the same thing with hospitals though, with DRGs, the services may or may not have all been delivered, and we don't do anything about that right now.

MS. BURKE: But the point is that it was easier when you bundled and I think my reaction is it isn't necessarily easier, which is not to suggest that bundling doesn't make sense for certain things, and that you will have to have a check on the system to ensure that in fact that predictive group of things occurred. But it does not a priori suggest that it is better or easier to do it by bundling, because it is not. It's easier to track it per unit because then either you did it or you didn't, you billed for it or you didn't, presuming the bill reflects what actually happened.

But I don't think one's easier than the other. I think bundling is more complicated but it doesn't mean it's a bad thing to do.

MS. DePARLE: Can I just make a suggestion too? If we pursue discussion of this, I think it helps--there is a table, Table 1, that talks about frequent episodes of care. If we could have this be a little more concrete as to what we'd be talking about. When I think of it as hypertension your points, Mark, make more sense to me and I can see why you would say that a bundle helps. When I'm just thinking about physicians, I'm thinking E&M visits, the way Ray was, so I have a hard time understanding how we would actually do this.

So if we bring in a panel or whatever, it would be helpful to be pretty concrete about what exactly they did and how they did it. Maybe like these 10 episodes of care, that's 31 percent, that's a lot. If you really think you could that, that might be worth doing.

MR. MULLER: I would say based on what I'm hearing here and perhaps what I think I heard Joe say is, I think it's a very important topic but not quite ripe in terms of where we are, because I think there's quite a different set of views around the table as to what we're bundling, and what the virtues of bundling

and unbundling are, and the effects on quality and so forth. So I'm also thinking about all the things we have to do in December without the November session, so we've got a lot of big topics there. So whether we could take three hours--this is more--scheduling thing is whether we could take three hours on this when we're not quite ready on this.

MR. DeBUSK: Should we even be pursuing this?

DR. STOWERS: I think the very least we need to do in the chapter is, if we're going to link bundling to quality is that we need to make the point, in most cases the more we bundle whether it be in an HMO model or whether it be in a DRG, whatever, brought on the great necessity of greater monitoring to make sure that the quality or no stinting was occurring. So really when you come to quality, the more you bundle, the less you usually assure quality.

A good example of that is bundling the E&M service. When I see a patient I'm responsible for the patient until the next visit all for that one E&M service. That's managing the home health care, that's managing getting therapy, that's managing--and yet what we're talking about is those things are not occurring. So when the management services came out of the AMA process to go, we're not paying and separating out a payment for management. I think we'd have been a lot better off unbundling the E&M to include some of the management things in between so the we were getting this quality, coordination of care, that kind of thing. So I think we at least need to look at the flip side of that in the chapter.

MR. HACKBARTH: Okay, we need to move on to the next item, so thanks, Kevin.