MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, October 28, 2004
9:32 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Provider profiling
-- Anne Mutti, Kevin Hayes

MS. MUTTI: This presentation builds on the examination that MedPAC did in examining private sector purchasing strategies that we included in the June 2004 report. As you may recall, for that report we interviewed a number of plans, purchasers and consultants and asked them what strategies they were using to contain costs. The vast majority reported that they were profiling or measuring physicians, as well as hospitals in some cases, on their resource use as well as quality.

A lot of them also mentioned that they were pursuing the strategy, and a large part as a result of the John Wennberg, Elliott Fisher and other research finding the wide geographic variation in practice patterns. And that often the practice patterns that were the most intense did not improve the outcome for patients.

So today we are hoping that we're responding to your interest in this topic, I think you expressed it last spring when we talked about it also at our strategic planning meeting, and then just moments ago.

So today our question is can provider profiling be used by Medicare to measure relative resource use? And what are those mechanics and issues that are involved in this exercise?

We recognize that measuring resource use is only part of the picture. Of course, you need to consider quality measures also, and they really should be used in tandem to determine what kind of efficiency you're gaining, what kind of value you're gaining for your Medicare dollars spent.

Our focus today is on physicians. In large part, this is because they provide a lot of the care and direct even more of it. It's also a first place for us to start. We're hoping also to look at resource use measures for hospitals and look at integration of measuring resource use for both physicians and hospitals together.

For context, let's start by looking at the definition of profiling and Medicare's role in profiling today. Profiling is a technique that examines providers patterns of care in terms of both quality and resource use. It involves obtaining information from large databases such as claims data to identify a provider's pattern of practice and then compare it with those of similar providers or within an accepted standard of care.

Medicare today does not profile its providers for resource use. As Ariel mentioned, we do profile for quality to a certain extent. The QIOs can go out and look at claims data and profile physicians on the frequency with which they provide certain services, like mammograms, flu shots, maybe eye exams for diabetics. These results are shared with the provider to give

them some idea of how they are standing, what areas they may have for improvement. But that information is not released publicly.

A few CMS demonstrations have encouraged providers to profile themselves. These include the heart bypass demonstration, which is akin to the Centers of Excellence concept, as well as the Large Group Practice Demonstration, which is expected to be launched shortly.

Also relevant here is that Medicare does not provide to the public or large purchasers Medicare claims data with unique physician identifiers. As we mentioned last spring, private purchasers have asked CMS to release this information. It would assist them in profiling their providers. It would make their data much more comprehensive. But at least as we've been informed, CMS feels that this violates the physicians' privacy rights. And so they are not able to do it at this point.

They are considering whether there's ways they could aggregate this information so that it would be useful to purchasers but still protect physicians' privacy.

This slide brings us to the mechanics of profiling and how resources are measured. Over the last few months, as we've talked to plans and vendors of software that's involved in this, we've learned about several main strategies. Common to virtually all are the patient care is risk adjusted and then the patient care is attributed or assigned to a physician or a physician group. Once that's done, the physician can be measured on a number of metrics. I should just note that these certainly can blend together and also can be used in combination with one another. But we thought at this point we would just list them separately to give you a better sense.

The first is you could calculate the rate of a given intervention. This could be the number of hospitalizations, the number of emergency room visits, the number of referrals per 1,000 patients.

The second is annual patient care spending. We found that this seemed to be particularly used by plans that had primary care providers acting in the gatekeeper capacity.

Thirdly, we learned about a metric that measures services used in episodes of care. Those services may be reflected in terms of either spending or standardized units. We also found that this was the most prevalent approach that we heard about. So for that reason, I think we'll spend a little bit more time making sure that you can understand and conceptualize what this approach looks like.

First, it's probably important to bear in mind that the scope of an episode can vary. It could be relatively narrow like just the duration of a hospital stay, including both physician and hospital services. Or it could be much broader. It could span across a year or two for a chronic condition if you'd like to measure the services delivered for that. It could be something in between also, all the services surrounding hip replacement surgery or maybe a bout of ammonia from the first visit to a physician, perhaps a hospitalization and follow-up

care, that could be the length of an episode.

Just to give an example of how the two can interact, once you've defined the episode of care you could look at the rate of a certain intervention, like the average number of lab tests done for somebody with hypertension.

To illustrate how episode profiling might work, I will describe broadly the approach of one of the most common products in the marketplace, Episode Treatment Groups. The episode starts with an anchor record, that is a claim for a physician visit or a hospital stay, for example. Then the episode includes related services for the condition until a clean period or a period where no claims are filed is detected. Each episode has its own length of clean period. Different episodes can occur simultaneously. That's entirely possible. And chronic conditions may be considered year-long episodes.

The grouper software is key to identifying which claims are related to the same episode. The ETG grouper sorts claims into more than 500 types of vendors. We heard from other vendors where there was a lot more types of episodes.

Ideally, the grouper categorizes episodes into clinically homogenous categories that account for different levels of severity and link complications to the underlying condition, recognize the complexity inherent to comorbidities, and also link together related conditions such as hypertension, angina end ischemic heart disease.

Once the grouper categorizes the care into episodes, a provider can be measured on the resources used for that type of patient, both the total resources and then the distribution of resources by service.

A host of measurement choices also need to be to addressed, however, to improve the accuracy of the profiling. These questions involve what the peer group may be, what type of care you're measuring, are you measuring all the care the physician providers or just a subset of it, what is the outlier threshold. We'll touch on these questions again later, but let me move on to something else first.

The idea of this slide is to give you an idea of what an output of resource use profiling can look like. As you can see here, we're comparing a peer group to physician A. We have the average charge per episode. And then we divide it by service category. You can see physician visits, diagnostic and lab tests, et cetera. On the far right-hand side is the overall efficiency score.

Here we presented it in terms of standardized dollars. You also have the option of presenting it in sort of relative value units, similar to how we do with physicians in Medicare. And here we also have standardized the spending.

Again, this is just an illustration. I actually made these numbers up. So the exercise of standardizing is also a fictitious one here, but the concept is what I want to get across.

A plan or Medicare, if they would like to reflect a dollar

value, can standardize for differences in payment levels for geographic that we've already built into our system for differences in payment levels for geographic regions as well as special mission hospitals, DSH and teaching hospitals you pay more for. You may not want to penalize them. You might want to try and level the playing field here when you present the dollar value. So you can standardize that and deal with that issue.

In this illustration, Physician A uses more services than his peers. That is why he has a 1.20 score. And in particular we can see that Physician A uses more hospital services than his peer group. On other service categories, he or she looks very similar to the peer group.

There are at least two critical attributes of effective profiling and really, these are quite common sense attributes, but they still are worth going over. The first is that it needs to produce accurate conclusions. By accuracy, we mean that it needs to reflect differences in practice style, not the relative health status differences of their patient panel, not statistical error, and not incomplete or erroneous data.

Unfortunately though, there's little empirical evidence on the accuracy of episode measurement or on what the most appropriate level of resource use is. Instead, most often plans are relying on a comparison to the average resource use of a peer group. which may or may not reflect appropriate use.

Private purchasers and researchers also suggest though that profiling might not have to be perfect to be useful. They point out that the alternative is the status quo, which allows for no feedback on the variation and has resulted in an overuse of quite a number of services.

Private sector purchasers also note that the accuracy may be improved by using techniques that improve statistical confidence. This may be requiring a very significant number of episodes per physician before you actually evaluate them. It may also involve looking at their resource for only their core services that they provide, really the bread and butter of a given specialty may be the ones that you really want to focus on and may eliminate some of the variation that you see as a result of health status differences.

A second attribute of effective profiling is its ability to encourage physicians to evaluate their practice style and modify it when appropriate. For this to occur physicians need to find that the profiling measures are clinical meaningful, that the process of measurement is transparent, and that the results are presented in a way that is actionable to them.

By actionable, I mean that the information is sufficient to inform a physician's evaluation of their practice style and suggest a way in which they may be more in line with their peers, if they feel that that's appropriate.

A number of design issues need to be addressed in implementing profiling. I'll touch on them briefly but we're hoping that our future work will flesh this out more and we can give you some more information as we do.

A fundamental question is how to assign patient care to a physician. This task is complicated by the fact that many beneficiaries see many more than one physician and then who do you attribute their care to? How much and what type of care should a provider deliver before she or he is held accountable for the patient's care? Should they be held accountable for their colleagues decisions?

On one hand, I think some people would say yes, that is entirely appropriate. We want a physician to be invested in the total efficiency with which a given beneficiary's care is delivered. Others will point out that in some cases they are not in control of what their colleagues decide for their treatment choices and they're uncomfortable with that kind of designation.

Another question as to consider what kind of care is measured. As we mentioned, it could be all the care, it could be chronic care or acute care that you're looking at. It could be care that you find to be particularly high cost care and that would be where you want to start in your profiling. Or it might be care for which we also have quality measures. That's something to think about also.

Another question is what is the appropriate benchmark? Are we looking at comparing similar specialties to one another? Are we looking at similar geographic regions? Those are things to think about. Another question is how to integrate hospital and physician measurement, as I mentioned before.

On this slide, there's a series of perhaps more technical questions, how to adjust for relative patient risk? I have referred to this so far. Ideally, a grouper adjusts for this health status and severity of illness differences, but we know from experience that risk adjustment is imperfect. Are there other ways to improve it just beyond getting a sophisticated grouper?

How do we account for outliers? Outliers are patients that have exceptionally high or perhaps low costs. How do you want to consider those? Do you want to still count those against a physician? And similarly, what is the minimum number of observations that you want to bear in mind? This is how many patients or episodes must be assigned to a physician before you're comfortable measuring that physician on their resource use?

Lastly on this slide, is how to adjust for care delivered at special mission facilities? This get at the idea of those facilities that are teaching or DSH hospitals. How do you account for the high costs associated with their missions?

I think this is a sampling. I don't think this is an exhaustive list of the kinds of issues that would have to be addressed, but I think it gives you an idea.

So at this point, I'll turn it over to Kevin and he can talk about next steps.

DR. HAYES: Just to briefly recap, we know then that the private purchasers are often using profiling methods. As you can see from Anne's presentation, we've learned a great deal about

those methods already. We're in a position now just wanting to know how they would work in Medicare.

So our next steps in this effort involve applying profiling methods with Medicare claims data.

Given what we've learned from private purchasers, from consultants, from software vendors, it's pretty clear that these episode-based methods are state-of-the-art. And so we would proceed with using those methods.

In doing so, we can then pursue a whole series of interesting questions like which episodes are the most frequent ones experienced by Medicare beneficiaries? During those episodes how does resource use vary, among market areas or whatever other unit of analysis we can pursue? Also, which services are driving that variation? Is it the types of imaging services that Ariel was talking about?

The other thing that we would encounter whenever we apply these methods is that we would confront some of the interesting design issues that Anne was talking about. For example, how sensitive are the results to outliers? What about this matter of focusing on all episodes furnished or managed by physicians versus focusing in on just those bread and butter core episodes that physicians are managing within a given specialty?

So in short then, what we're trying to do here is to sort of operationalize the methods that we've heard about in the private sector and see how they would work in the Medicare program. This would include exploring the opportunities to try and integrate profiling methods not just for physician services but hospital care and other sectors as well.

That's kind of where we are with the project at this point. We realize that the presentation today and the paper we sent you for the meeting covered a lot of material. A lot of it is not all that intuitive and that, too, was part of the motivation for turning now to the data to try and put together some more concrete application of these methods and bring back to you some examples of how the methods work.

In the meantime, we would appreciate your feedback on what you've heard so far and your thoughts about what you'd would like to see next on this topic.

MR. DeBUSK: On page five, it says apply a grouper that identifies clinical and homogeneous episodes, accounts for variation in severity. Is there quite a selection of software out there that will do this grouper piece?

MS. MUTTI: There seems to be one product that has clearly the majority of the market, but there are other products as well, at least other one.

MR. DeBUSK: May I ask what is that?

MS. MUTTI: The one is the Episode Treatment Group which was created by Symmetry. The other one that we spoke about, that we learned about, was the Cave method. Doug Cave Consulting has its own grouper.

MR. DeBUSK: Thank you.

DR. REISCHAUER: Most of this discussion has been of the

form can you do it? Can you get useful information out of this? And in the back of my mind is always a question of if you could, what would you do with it?

In Medicare, there are certain limitations in Medicare and I want to know from John and Jay, what do they do with it? Is it educational only? Is it used to exclude people from networks, which is sort of a much greater problem in Medicare? Is it used to vary payment levels of one form or another?

And also, when you begin doing this kind of thing, what do the distributions look like? Do you find in these tables that they are flat, in a sense, that 5 percent of the people? Or are they highly skewed, and you have a few people out there who appear to be extremely inefficient or providing a very different kind of care? And how much of Medicare's total expenditures are in that tail? So if you went through all of this and you aggressively then developed some mechanism for dealing with that. are you going to be saving 2 percent or are you going to be saving 30 percent?

DR. BERTKO: Arnie can probably respond to some of this, too, but let me respond with some direct experience we've had. For about three-and-a-half years we used both of the system for a variety of practical reasons. Arnie's colleagues are giving us some emphasis to use one of the systems and we have an interest in the other.

To your comments though. First of all, it's a significant amount of money involved. In our commercial populations we think the potential reduction on cost without any reduction in utilization -- that is for appropriate services -- is in the neighborhood of 10 percent. In our experiments in the Medicare data we have, it shows it's an excess of that, perhaps 15 percent or more.

Number two, your question, Bob, is what's the distribution on this? Not surprisingly, it varies by specialty. And without identifying the guilty parties, it's as little as 15 percent of docs in the outlier circumstance -- and we're doing that all not clinically but just on a strictly math basis, I don't want to make it anything else -- to as much as 25 percent.

We heard a presentation at a meeting that Arnie led by union group in Las Vegas that I think saved what, in excess of 15 percent? 10 to 15 percent by, in this case, eliminating a number of doctors from their network.

So to your third question about what could you do? One is to form new networks, which may not work for Medicare fee-for-service but certainly could work in the MA plan scenario.

Two, I completely agree with Jay. By far the majority of physicians not only are under the outlier but are clustered toward the mean. And this is not in the closed universe known as Kaiser but in the wide world that is our footprint across the United States. And I think there is, in Medicare, an educational ability to show docs where they are in these things.

Number three, on an anecdotal basis only, when we've gotten feedback for a physician saying why am I now not invited into

your network, we can show them and say your use of -- in this case, imaging and lab tests -- is 200 percent of the norm of your peer group in an area, which is entirely separate from is the area right. But it's way out there. And so the outliers, in many cases, are way up there with, at least on a cost basis, no reason that I can see for that high amount of use. They are severity adjusted in one way or another so we can pretty much toss the complaint.

We've had a fair amount of explanation done on transparency. I have used Doug Cave, in fact, to talk to docs and say this is what we did. And we adjusted it for severity this way. And the docs go oh, okay.

MR. HACKBARTH: John, when you say 10 or 15 percent savings, that is total health care expenditures?

DR. BERTKO: In a commercial world we bundle everything, professional fees, lab, imaging, inpatient, outpatient and prescription drugs. And yes, it's all bundled together. It's attached to the episode. Some of the technical questions are still out there.

I would also say that, if I can make one other comment here, whether or not Medicare uses this, the ability to either access data or even Medicare's interest on an educational basis I think could be very positive in terms of getting things to work better.

When you say that some private organizations have achieved savings on the order of 10 or 15 percent, is that through excluding -- total exclusion of certain providers? Or is that through a combination of education?

DR. BERTKO: What most do as far as I know, and this is an industry statement, is change the tier in which the provider is. So you can still go to any doctor, but typically the outlier docs fall into the out-of-network and then they would be higher there. But at the same time there is some amount of education.

I know of one other player using this who is doing only education. And presumably they're getting some effect from that.

MR. HACKBARTH: So if, for a variety of reasons, Medicare is a payer were unable to go to tiered networks, then the potential saving would be less than the 10 or 15 percent?

DR. BERTKO: I would assume that would be true.

MR. HACKBARTH: Thanks for the clarifications. Arnie?

DR. MILSTEIN: A couple of comments. First, if you were to look at the array of options for moderating future premium increase trend in the private sector and say which of these are the -- I will call it the more active end -- of the private purchasers spectrum and their insurers focusing on, it's this area. And it's precisely because there is very few other options that have this magnitude of yield, in terms of opportunity to moderate future premium increase.

The second comment is irrelevant to Bob's question. You sort of say once you develop these profiles, how are they being used? They are actually being used in all four conceivable

applications. They're being used for performance improvement coaching for doctors, being used for public transparency along the lines of that -- it's not Medicare beneficiaries that only have to pick a plan, but within traditional Medicare, given their out-of-pocket exposure, wouldn't it be nice if they had an opportunity to know which physicians in their community were less likely to burn Medicare benefits fuel and cause them to have more out-of-pocket exposure. So it's used for public transparency. It's used in pay for performance. It could be used and is being used in pay for performance, although it sounds a little counterintuitive to potentially pay providers more for being leaner in their whole resource use. If you think about it more carefully, it's actually not irrational at all. And the third is benefit design, in terms of tiered networks.

Some of those obviously would be much more difficult for traditional Medicare to reach than others. But some of them are applicable to traditional Medicare easily.

The second point is that obviously the importance of pairing this with best available quality of care profiling so that you're confident you're not pushing people to inappropriately lean physicians or encouraging physicians to be inappropriately lean. The good news is for those insurers and purchasers that have actually gone to the trouble of profiling physicians using best available methods not only for benefits fuel burn but also for quality, is that there are plenty of physicians that score very well on both. The two things have been shown to be not always correlated but sometimes very highly correlated.

Another key point I want to emphasize is as you think about any kind of performance measures in health care, whether they're quality measures or efficiency measures or measures of patient experience of care, we know going into it that the methodology is not going to be perfect. And so one of the questions that we will inevitably face is not whether it's perfect but whether it's good enough such that there would be more benefit to the Medicare program than risk?

John's point about the importance of the possibility of collaboration between Medicare and the private sector is very important. One of the interesting facets of all of this is the private sector, one of the barriers to them moving ahead is that unlike traditional Medicare, in most private sector insurance plans -- and the same would be true I think of many Medicare advantage plans -- don't have access to a big enough database size to have adequate stability of profiling. Access to the CMS database in patient protected formats would make all the difference in the world, both for Medicare Advantage plans and for traditional plans.

In terms of is it good enough, I want to say that for me it's significant that where provider organizations, physician organizations, are bearing any kind of insurance risk, they tend to us it which to me is a signal that imperfect though it may be, it's useful and that providers find it good enough when they themselves at the ones bearing insurance risk.

The last comment is that I think this issue of measuring and introducing some way of reinforcing physician conservatism and quality of care at the individual level, I think, will inevitably and hopefully be a part of what we'll call the SGR dialog that will be taking place between Congress and physicians and people who are -- I'll call it taxpayer representatives -- beginning in January. I would hope that we can make our recommendation on a time frame such that we are prepared and active and have a stated position by January because that's when the SGR – if you think about it, the SGR is a way of profiling all American doctors as a big clump and saying we're going to hold you accountable. If you think of it, it's a big pay for performance program. We're saying if you use a lot of services, we're going to cut back on your fees.

I think one of the challenges of that has been the unit of accountability. Doctors judged as a national lump are not -- it's one of these things where everyone is responsible and no one individually feels accountable. And it's a very problematic unit of analysis.

MR. HACKBARTH: Jay, in particular I'd like your reaction to Arnie's statement that providers, when they are at risk, do this.

DR. BERTKO: Glenn, may I correct, I think what Arnie said was that risk takers, namely plans, employers and other things, are the ones doing this, not necessarily the --

MR. HACKBARTH: I thought he was saying that providers -- Arnie, I interpreted your statement as saying that providers, when they're bearing risk, use this tool. And that's an indication, although it may not be perfect, they think it's useful. Did I hear you correctly?

DR. MILSTEIN: Yes.

DR. BERTKO: Plans maybe a little more than provider groups these days.

DR. MILSTEIN: Yes.

MR. HACKBARTH: Jay.

DR. CROSSON: Thanks. And I was going to make a comment at least tangentially on that. Again, to predicate this, I'm not sure that the model that I'm used to is exactly equivalent to what we're describing here. The issue of profiling, and we don't use that term in the prepaid group practice world that I live in, is a delivery system issue. It's not a plan issue, number one.

And it's not necessarily related to stark financial risk. It's predicated, I think, in the group practice culture on the belief that there is a better way to practice medicine. And that is supported by scientific evidence, which admittedly changes over time. But that knowledge of and distribution of that information over time changes physician behavior because physicians, for the most part, are responsive to facts and change their practice when they are given that information. And so that's how we use it essentially. We use it is both an educational and a management tool in the culture of a group practice.

We do not distinguish between quality and resource use. We

view those as two issues which fall out of the process of organizing scientific evidence to guide practice. It's a cultural phenomenon. It's a management phenomenon. It's actively supported by these patterns of practice are not something that are extrinsic. They are developed by the physician specialists within the group in order to guide themselves and others. And that's how it is.

MR. MULLER: I want to echo and endorse that profiling is a good way for Medicare to go, not just because private plans are doing it but because providers use it as well. So I will endorse what Arnie and John and others have said, that providers do use it when they're at risk. In many ways, you can say having a DRG payment puts you at risk, and APCs are more recent.

I'm just personally familiar with using it in my organizations for 15 years now, in terms of looking at patterns utilization against DRGs.

I think it's fair to say my experience too is that -- I think John said this earlier, there's a lot of cluster around the mean but then a lot of big outliers. There is therefore a lot of fruit to be borne in looking at those outliers.

What makes it more difficult is for all of the reasons mentioned earlier, you can get the outliers back to a mean but it's very dynamic. The patterns of practice change so quickly. So let's say if you get some urologist or orthopods or whatever -- it's easier to do in the surgical areas than it is in the medical areas, you get them back to some kind of norm. And for the reasons that John and Jay have mentioned, people want to be within the norm as opposed to being way outside of it.

But all of a sudden, some new pattern of care comes up within a year or two, and then people become outliers again within that pattern. So kind of fixing this for a set of practices or a set of physicians doesn't stick very long. So I think one has to think of this in dynamic terms, that you don't fix it in orthopedics or in general surgery, thoracic surgery, for five or 10 years at a time. You may fix a particular issue you're looking at, in terms of putting evidence in front of people. Physicians are evidence-based. They want to do the right thing and comply with it, whether it's regional norms or professional norms.

But then some other practice comes up, whether it's driven by innovation or device manufacturers or whatever. The new techniques come out and one has to start thinking again about what the distribution of patterns of care are against that. So I think it's both important to keep looking at this direction, understand how you have to constantly stay on top of it and how dynamic it is. But yet I think it's incredibly fruitful because you do find enormous variation in a small cluster. And if one can change those ways, there's a lot of benefit to be gained.

And I think the evidence that obviously that Wennberg and his acolytes have shown is that the quality doesn't necessarily suffer if you put people into those kind of norms. So I do think there's a lot of provider evidence. In many ways I would say

there's probably many years of provider evidence on it, if you look going back. Because I think from '83 on people had to start reacting to DRGs. So there's probably 15 years, if not more, of evidence there. Again less apparent on the outpatient side, because the risk wasn't there as clearly until the APCs came in.

I think if you want to look at evidence on this, I would look in that area as well.

DR. REISCHAUER: This builds a little bit on that point. We do know that there's this huge variation across region in practice patterns. The Fisher and Wennberg kinds of information is a big glom and it's been treated by policymakers as interesting but...

It strikes me that risk-adjusted episode-based profiling for physicians or providers in Rochester and Minneapolis versus Miami and Los Angeles could provide some important information to policymakers that would cause them to ask questions and change the nature of the debate on these kinds of issues. And you don't have to have identifications of providers or anything because what you're really looking at is average distribution of docs with respect to this and comparing them across geographic areas for similar risk-adjusted episode of care. And we do know something about health outcomes at the Metropolitan level.

And so this could be a very useful piece of information for policymakers, one that they may not want.

MR. HACKBARTH: I think this touches on sort of the central question for the Medicare program as we move forward. Our tendency in the past has been to treat all providers as though they are the same. When we have cost problems we squeeze everybody across-the-board.

Given the dimension of the challenge that we face going forward from here, personally I think that's a bankrupt strategy. We will do great detriment, great harm, to our health care system, to good providers, to beneficiaries if we insist on this across-the-board, across-the-board, everybody's the same. At some point, although it's hellishly complicated and controversial, you've got to start to dip in and say not everybody is the same. This is just one of many potential ways that you start to get into that conversation. Hence my strong interest in it.

I wanted to get commissioner reaction to Arnie and John's statement that even if Medicare felt that for whatever reason it was unable to use the information itself, it could do a service by making the Medicare information, including the provider identifiers, available to private payers.

I think, Arnie, I think you were the one that gave me the formulation that Medicare is rich in data and is sometimes hampered in its ability to act on the data by political, legal and other constraints. Private payers have somewhat greater flexibility to act but lack the data. So this is a potential marriage of relative strengths. I want to hear what other commissioners think about that.

MS. BURKE: I think it would be a mistake at this point in

time. I think, Glenn, you said exactly what I would hope the commission would say was the extraordinary importance of Medicare beginning to develop this information and utilizing it in the context of the Medicare program and how we structure reimbursement, in how we inform physicians about their practice, for purposes of education and ultimately for purposes of reimbursement.

I think to provide the information to private payers in advance of our making a decision to use it for the Medicare patient would be an enormous mistake. I think if there are politics in our using it for Medicare patients, the politics of us providing it to payers who will, in fact, use it for purposes of excluding people from coverage, from groups, I think will complicate our long-term strategies to use it effectively for Medicare.

I think the political response to that will not be a positive one. But I think we ought to certainly develop it and we ought to state it's importance. We ought to state the value of moving in the direction of using it for payment purposes and education purposes. But I think to allow it to be used for private payers in advance of it being used constructively for Medicare would be a mistake.

DR. WAKEFIELD: I can't speak to the timing issues that Sheila just raised but I can say that some of the feedback that I here is that it's difficult, using North Dakota is an example, it's difficult to really assist individual providers in better understanding what's going on with their patient population when they have only part of the data available.

So what we hear, for example from Blue Cross Blue Shield representatives, is that they'll feed back their diabetes registry information to individual providers. But they're missing a huge set of information if those providers are caring for a significant -- and in my state it is case -- a significant portion of the patients they see are Medicare beneficiaries.

So what gets fed back to the individual provider is what's going on in the private pay side, but they don't have any of the rest of it. It's an incomplete picture. And I think that does a disservice not just to the provider but ultimately to the patients whose care we're trying to assure is high-quality care.

I don't disagree necessarily about timing issues. I defer to Sheila on the politics of all of this. But where the rubber hits the road, I think there's an issue there if we're only providing people with half the picture. In my case, in our state, probably less than half the picture right now.

MR. SMITH: On Medicare data to private provider question, I think Sheila is exactly right. Turning the politics of this into a fight of what a private provider did with public data could well cramp and eventually inhibit our ability to use the public data publicly. I think Glenn, your formulation earlier that it's time to collect, it's time to figure out how to use this data in Medicare itself is where we should go.

But putting our ability to do that at the risk of the

political backlash of the way that data is used before Medicare gets to use it by private payers would be a big mistake. Not just a timing mistake but a political judgment mistake.

MR. DURENBERGER: I think I'm reacting also to what Sheila said and maybe suggesting by way of example of a way to think about it. I have found, in my own analyzing of the Medicare Modernization Act, in one of my PowerPoint's -- I don't know why we're in a barn today. But I've got this little PowerPoint of looking for the pony in the manure pile. For me, the pony is the regionalization. I went through everything that Sheila has talked about. We've all had this experience. When we did RBRVS in 1989, I debated then with Gail Wilensky about the volume performance standards, and when they're applied across the country they penalize the folks in the Upper Midwest more heavily that they will penalize other people. Is there a resolution? Arnie said sure, there's a resolution and we ought to get it in January.

But one of the things that is so important, as I've experienced this, about the regionalization potential is not how do we get more benefits to people and things like that. But how do we appeal to the provider instinct that Jay has spoken to and many of us know to do things better and differently if only we have the information on which to do it.

While I am sure people tire of the Miami-Minneapolis comparison, let me say Minneapolis is going the way of Miami simply because we haven't dealt adequately with some of these issues.

I've observed frequently in recent months that if I had known -- and even though Sheila was there, I didn't know -- if I had known in 1982 or '83 what I know now, I would have done my best to formulate Medicare's payment policy around what became known as the TEFRA risk contracts with HMOs in Hawaii, the Pacific Northwest, Intermountain, the Upper Midwest, and New England. And I would have said everybody else, you take the DRGs because you don't have the cultural capacity to change unless somebody gives you these kind of regulatory incentives.

So with that in the back of my mind, I think that what has been suggested by way of applying this to the Medicare claims data is really important. But perhaps contexting it in some suggestions about moving this regionalization process more quickly past the drug benefit, the PPO benefit and starting to think about providing incentives for these naturally occurring regions in this country to use this kind of information to change the way in which we use resources, improve quality and so forth.

So it's not a difference in terms of the politics of it? I acknowledge that is a reality, although I think that's changing, too. But I think there's a more positive way in which we could present this.

DR. BERTKO: Glenn, may I respond as a quick follow-up to this?

MR. HACKBARTH: Very quick.

DR. BERTKO: I acknowledge what Sheila said, but there is a

chicken and egg element, continuing the barn, in that if there's regionalization run by private plans my comment would be that they will run better and be more likely if, in fact, access is available to this data.

MS. BURKE: Let me say the following. I think the extent to which you can begin to provide information that provides guidance, or information that is nonspecific to individual physicians, that is Medicare data that can assist in determining patterns in regional areas, it makes enormous sense.

It is the individual identifier that would allow private payers to make decisions on payment based on Medicare data that troubles me in advance of Medicare -- now to Nancy-Ann's concern, there's no question that we have to find a way to get Medicare to move quickly to begin to use this information and gather it. And I think we ought to be a strong as we can be in stating the importance of Medicare moving in this direction for purposes of payment decisions and education decisions. I don't think in any way we should intimate that we don't think this is the direction to go.

But actually providing the information on a specific physician basis so private payers can make payment decisions based on Medicare data before Medicare has done so, I think would. in fact, reverse the trend. I think it would, in fact, impede us in moving forward.

So I think if we can get regional data, get the information out, show the trends, provide the information as best we can to private payers to utilize it, great. But it is that next step that I think moving too quickly and allowing decisions to be made before Medicare has done so would be a big mistake and would, in fact, create problems that will, I think, impede us moving forward.

But I think we ought to be as strong as we can in stating this is exactly the way Medicare ought to go.

MR. HACKBARTH: I really need to get Bill and Nick, both of whom have been waiting patiently. Arnie's had his hand up for a while and we are a bit behind schedule. And we have a panel from the outside right after lunch, so I really don't want to keep guests waiting. So we've got a fairly rigid time limit here.

DR. SCANLON: I'll pass because Sheila just said essentially what I wanted to say.

DR. WOLTER: Since I'm naive about what's possible, I'll weigh in on the side of trying to find a way to actually have the Medicare data be used. I would use the analogy of what's going on the public-private partnerships about quality measures because there's another aspect to this. That is that providers don't want this coming at them from multiple different sectors. They would like it to come in a way that seems consistent.

And I think if that could happen, there would be a huge interest actually in responding to how we take this episode profiling and try to make health care better.

I'd also say that there's a fair amount of urgency to this. If there's a 10 or 15 percent savings potentially on the table, I

don't think we have a lot of time to go after it. That's how I would look at it.

And then philosophically, I would also add that there's the 10 or 15 percent that might come from addressing the outlier issue which, of course, gets us to average practice. It doesn't get us to best practice. I think that to get to best practice, that's where we need to think out of the box about how incentives can look at Part A and Part B together, so that we can really drive to best practices.

Because I don't think that the skill sets around process and improvement are inherent in training that most physicians get. It takes pharmacists, nurses, quality improvement people, and that's where you really have to have teams working cooperatively.

So the incentives need to move beyond the SGR down -- I don't know if it's the individual level. It's certainly at the practice level, in some fashion. But that does involve teams, which means we have to look at the silos of payment and come up with new approaches.

MR. HACKBARTH: Arnie, a very brief comment.

DR. MILSTEIN: I think Sheila's prediction that the availability of Medicare data at the individual physician level carries major political challenges. But the other side of it is that it is exactly that information set that is the key to unlocking this 10 to 15 percentage points of opportunity to moderate premium trend. And also it's key to what the last two commenters point about building a market in which Medicare and the private sector are a little bit better synchronized in terms of their evaluation of performance and their reward for it.

That's really, if you read the IOM Crossing the Quality Chasm Report and you look at their map as to how we might get across the chasm, and move from average practice to very best practices and discovering tomorrow's even better practices, it really is built on this idea of sort of a synchronized market in which private plans, purchasers and Medicare are using the same performance measurement stream and using that to evaluate not just health care organizations but also, to use the IOM's language, patient facing microsystems which could be individual docs in some parts of the country or they could be physician office units in other parts of the country or even bigger units of analysis in the case of Jay's organization.

I just think it's one of these things, we have a set of trade-offs here. I think Sheila has correctly characterized it that the politics of doing this in individual physician level of analysis are challenging. But I think it's offset by it being a tremendous leverage point for performance, not just standardization, but by performance breakthrough along the lines of what the IOM is telling us.

MR. HACKBARTH: Okay. We'll now have our public comment period with the usual ground rules. Please keep your comments very brief. We are up against a time constraint.

If someone before you in the queue makes your comments,

please don't repeat the same thing over, just signify your agreement with that.