THE BROOKINGS INSTITUTION

FALK AUDITORIUM

THE MEDICARE PHYSICIAN FEE SCHEDULE AND ALTERNATIVE PAYMENTS MODELS

AN EVENT FROM THE USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY AND THE URBAN INSTITUTE

Washington, D.C.

Tuesday, September 26, 2017

PARTICIPANTS:

Introduction:

ERIC SCHNEIDER
Senior Vice President for Policy Research
Commonwealth Fund

ROBERT BERENSON
Institute Fellow
Urban Institute

Session 1: Physician Fee Schedule: Origins and Evolution:

LAUREN LeROY, Moderator
Strategic Advisor
LeRoy Strategies

PAUL GINSBURG
Senior Fellow and Director
USC-Brookings Schaeffer Initiative for Health Policy

CHIP KAHN
President and Chief Executive Officer
Federation for American Hospitals

BARBARA LEVY
Vice President for Health Policy and Advocacy
The American Congress for Obstetricians and Gynecologists

MARK MILLER
Executive Director
Medicare Payment Advisory Commission

Session 2: Relationship Between PFS and Alternative Payment Models (APMs):

ROBERT BERENSON, Moderator
Institute Fellow
Urban Institute

MAI PHAM
Vice President, Provider Alignment Solutions
Anthem

SIMEON SCHWARTZ
Chief Executive Officer
Westmed Practice Partners

FRANK OPELKA
Medical Director for Quality and Health Policy, Division of Advocacy and Health Policy
American College of Surgeons

GRACE TERRELL
Chief Executive Officer
Envision Genomics

ALAN LAZAROFF
Medical Director for Quality and Coding
Physician Health Partners

Luncheon Panel:

STEPHEN ZUCKERMAN, Moderator
Co-Director and Senior Fellow, Health Policy Center
Urban Institute

VICTOR RODWIN
Professor of Health Policy and Management
NUU Wagner

ANTOINE GROULX
Deputy Director General of Health Services and Academic Medicine
Quebec Ministry of Health and Social Services

SIMEON SCHWARTZ
Chief Executive Officer
Westmed Practice Partners

Session 3: Establishing Relative Values: Challenges and Options:

KATIE MERRELL, Moderator
Senior Research Analyst
Actuarial Research Corp.

JOSEPH NEWHOUSE
John D. MacArthur Professor of Health Policy and Management
Harvard University

STEPHEN ZUCKERMAN
Co-Director and Senior Fellow, Health Policy Center

Urban Institute

PETER HUSSEY
Senior Policy Researcher
RAND Corporation

ANTOINE GROULX
Deputy Director General of Health Services and Academic Medicine
Quebec Ministry of Health and Social Services

Session 4: What's Next for the Physician Fee Schedule?:

PAUL GINSBURG, Moderator
Senior Fellow and Director, USC-Brookings
Schaeffer Initiative for Health Policy

ROBERT BERENSON
Institute Fellow
Urban Institute

GAIL WILENSKY
Senior Fellow
Project HOPE

JONATHAN BLUM
Executive Vice President, Medical Affairs
CareFirst BlueCross BlueShield

KAREN FISHER
Chief Public Policy Officer
Association of American Medical Colleges

ERIC SCHNEIDER
Senior Vice President for Policy and Research
Commonwealth Fund

Closing Comments:

PAUL GINSBURG
Senior Fellow and Director
USC-Brookings Schaeffer Initiative for Health Policy

* * * * *

P R O C E E D I N G S

MR. BERENSON: Silence has descended and the doors have closed so I guess that means we should get started. Thank you all for coming. There will be people coming in, some people going out, and I think we have a little competition from down the street from Graham Cassidy, although perhaps that will dissipate as the day goes on.

Thank you for being here. I want to make some introductory remarks and then introduce Eric Schneider from the Commonwealth Fund to welcome you and then I'll go through what the panels will be doing today to try to encourage you to state throughout the whole day.

This all started, I don't know, six, eight months ago when I guess Katie Merrill who is one of our planning committee members noted that it's the 25th anniversary of the Medicare Physician Fee Schedule, maybe we should celebrate. That wasn't exactly the words. (Laughter) One thing led to another and we decided to just sort of have an anniversary of the Fee Schedule wasn't going to accomplish very much for advancing healthcare policy but exploring the interactions of the Medicare Fee Schedule and the broad aspiration of moving toward value-based payment, through alternative payment models was a topic worth exploring. We got interest from the Commonwealth Fund to support this activity, and I want to introduce Eric Schneider to say a few words. Eric, by the way, is the senior vice president of Commonwealth. He's going to be on a panel later so you'll hear a little more about him.

MR. SCHNEIDER: Thanks very much, Bob. Welcome everyone, good morning. I'll be very brief. It's a delight to be here on behalf of the Commonwealth Fund supporting today's meeting examining the history and future of the Medicare Physician Fee Schedule and its role in payment reforms.

I realized this morning coming over here that I had lived my -- I was a practicing primary care physician for about 25 years and I realized I lived most of my life under the Physician Fee Schedule and had always thought that this was delivered on tablets to Moses at Mt. Sinai. (Laughter) But now I understand and of course as a researcher I understood that there was actually quite a detailed process for coming up with the Physician Fee Schedule.

So, the Fund for those of you who don't know us are going to celebrate our 100th anniversary next year, so we've had the mission of advancing high quality affordable healthcare for everyone for quite a long time. The Medicare program is crucial to that mission, and enabling access to

physician services was a cornerstone of the passage of Medicare and that continues to be so today.

I'll probably leave it at that other than to say that the Fund has over the past 25 years supported several investigators, probably many in this room, to better understand how to pay physicians and others in the healthcare delivery system and to understand the impact of programs.

I think one central question for us is whether this elegant solution, the Physician Fee Schedule, is a bit like Alexander Graham Bell's telephone, an elegant solution for its time which has then been superseded by advances that have now put smartphone computing platforms in all of our pockets. So, that's the image that I've been carrying in my head today; is this a tool that can sever in future advance payment models as we move forward in the future?

But more to say about that. We're looking forward to learning about all of these topics throughout the day today. So, thank you Bob.

MR. BERENSON: I want to take us back briefly and then panel one will do a little more of that to where we were back in the late '80s when the work on the resource-based relative value scale that resulted as the basis for the Medicare Fee Schedule starting in 1992, what was the problem, what was the solution. A quote from the Physician Payment Review Commission, which was a predecessor commission to MedPAC and concentrating on physician payment: "The more it learns the stronger its conviction," this is PPRC, "becomes that the pattern of relative payments based on screens for customary prevailing and reasonable charges has serious problems. Rationalizing the pattern of payment is the key part of reforming Medicare."

And in fact one could find other quotes that viewed the RBRVS reforms as part of the Medicare Fee Schedule as -- actually we invited Bill Hsiao to come today and he had a conflict but regretted that he could not be here -- but I remember him writing about how he used the case of an ulcer which most physicians treat now with medication and it's not as big a deal as it used to be, it used to be patients got sent for upper GI series and it was a whole workup, that's before we realized it wasn't an infectious disease. But his point was if we paid more appropriately within the Fee Schedule, more time with patients, less incentive to order tests, there wouldn't be a need for all that upper GI series and people would have more time with their physicians. He was using that to sort of describe the potential of increasing value within the Medicare Physician Fee Schedule.

Going back, I want to take a minute or two to read another quote because I think it is a lesson in humility for all of us as we look at value-based payment and what the potential is. Let me read this quote. "In contrast to budget policy in recent years that concentrated on reducing price, expenditure targets would provide an opportunity for physicians to help achieve its cost containment objectives through actions to slow the increase in utilization of services. A collective incentive would be given to the medical community to reduce services of little or no benefit to patients. While not providing direct incentives to individual practitioners such a policy would encourage the leadership of medicine to become more active in the support of activities to better inform physicians about the medical benefits and risks of procedures and to play a more active and constructive role in peer review activities. Expenditure targets would send the message that the need to slow the rate of increase in program and beneficiary outlays and provide physicians with constructive ways to respond."

Well, in hindsight that was wrong. We had the volume performance standard and ultimately the sustainable growth rate and the sort of policy wisdom about that was that the collective incentive doesn't work very well. It's more like the tragedy of the commons when each individual tries to get a larger slice of the limited resource.

So, that was wrong but it was well-intentioned. I raise that as the context for when this Fee Schedule was being described and invented. It was actually one of the payment reforms called Perspective Payment along with DRGs, and ultimately the Balanced Budget Act of '97 had virtually converted all of the Medicare fee schedules into some form of perspective payment with the idea that it would be a more rational system for constraining spending, et cetera. So, it is interesting now to see that the Fee Schedule is sort of a prototype of fee-for-service, fee-for-service is volume-based, volume-based has to be replaced, and we are moving down the road to alternative payment models. And yet we still have the Fee Schedule. And in fact most physicians in private and in government payment systems are being paid fee-for-service.

So, what we want to explore in detail is what are the interactions between the Fee Schedule and alternative payment models and what is the role of reforming or improving the functioning of the Fee Schedule to better support the objectives of alternative payment models to increase value for beneficiaries and taxpayers.

So, we have four panels that will explore this in some detail. Panel one will explore in more detail the original intent and how it has evolved over the 25 years. We'll talk about current reform ideas that have not yet been implemented as well as those that have.

Panel two will be a physician panel, physicians who have been actively involved with alternative payment models, whether it's bundled episodes or capitation, the forms of shared savings in ACOs, but also are very knowledgeable about the Medicare Physician Fee Schedule to comment on the those interactions and how to provide greater complementarity or synergy between the two approaches.

The third panel will be more technical in nature. It will explore some of the alternative bases for establishing relative values. We moved from charge limits to resource-based back in 1992. There are some other countries that look at trying to achieve target incomes for different specialties. There are approaches to used behavioral responses to fee changes. We have some experience with that actually in the U.S. but in Japan they have reduced the price of MRIs consecutively until they see a behavioral response that might suggest access problems. So, they are using sort of market factors to adjust fees. Then there is the possibility of using policy objectives to later fees. In the U.S. CMS does not have the authority to do that, Congress has to do that, so Congress can for a period of time provide a 10 percent increase, for example, for primary care physicians' ENM services, but CMS within the constraints of the statute has to sort of assess resource costs. We will explore those details and other technical aspects of the Fee Schedule.

And then finally we will have a policy panel on the issue of is it worth it if there's a broad consensus that fee-for-service is volume-based and really a remnant of a previous time, and should we be extending the opportunity costs to even improve the Fee Schedule rather than moving more assertively to alternative payment models. We will have a policy discussion about the role of fee schedule improvement in a world of alternative payment models.

We will also have a luncheon presentation. The program was a little vague about what that was all about. It's because we had a speaker scheduled to come from Berlin who is an expert on European healthcare systems and a week ago he informed me that he had been on the queue for an adoption and it came through last week. A ten-day-old baby. So he is very happy, we are very happy for him, but he could not come. So we quickly pulled together three other experts on Canada, France, and

the UK to give a flavor for how other countries are viewing payment to physicians, the role of their established payment model, and the goals of increasing value. So that's what the luncheon session will be about.

So, with that I want to stop and -- hello, Grace -- and turn it over to panel one. We're a little bit behind schedule but not much. So, I hope you can stick with us all day, if not we will be streaming, et cetera. There will be others coming in. It will be I think a substance-filled day and thank you for coming. So, with that it's time for panel one. Lauren, it's yours. Thank you.

MS. LEROY: I too want to welcome all of you here today. I'm Lauren LeRoy, I'm currently working as an advisor to private foundations, government agencies, non-profits, and others that work in the health arena. I was asked to moderate this panel, I assume, today because I was initially the deputy director working with Paul Ginsburg of the Physician Payment Review Commission, tried to follow in his big shoes when he left as executive director and was the first executive director of MedPAC. I'm very much looking forward to the conversation today and to the presentations we have before us.

As Bob said, 25 years after the Medicare Fee Schedule was introduced it's still the dominant form of payment for physician services, but it's under stress in its traditional role and it's facing new demands as many alternative payment models in which physician compensation is based on it are being developed and implemented.

PPRC developed its recommendations for the Medicare Fee Schedule in 1989, and later that year the Congress passed legislation that enacted the parameters of the Medicare Fee Schedule as well as provisions to protect beneficiaries and to attempt to restrain spending growth. As Bob said, one of the defining words behind the motivation for the Medicare Fee Schedule, or the defining concepts, was to rationalize physician payments by tying them to the resources required to deliver specific services. It was assumed at the same time that while this would lead to more equitable payments to physicians that more was likely to be needed to try to control spending or to affect the volume of services. So further provisions both targeting spending and providing information and tools to physicians to encourage more appropriate care were also included in the legislation.

Now, fast forward to today. We're still grappling with disparities and compensation between procedural specialties and primary care, with how to keep up with changes in medical practice

when valuing procedures or evaluation and management services, with how to restrain volume and expenditures and with how to transform healthcare delivery to improve quality in the appropriateness of care.

One could argue that as we look to the development of alternative payment models which will define physician payment in the future that there is considerable continuity between the challenges that were faced when the Medicare Fee Schedule was enacted and current efforts to try to reform payment. And there is also much to be learned from the last 25 years of experience.

Each year the PPRC report to Congress began with a chapter called the “Context for reform.” Anybody who was working at PPRC at the time probably cringes when they hear that because it was always a challenging chapter to put together. But in some ways I see this panel as performing a similar role for us today, providing historical context and discussing more recent developments that can both provide background and frame the topics for the sessions that follow during the day.

We have four terrific speakers, so let me quickly introduce them so we can get on with the program. First, going back to 1989 we have Paul Ginsburg sitting here to my right who is currently the director of the USC-Brookings Schaeffer Initiative for Health Policy. That is a mouthful, Paul, I have to say. (Laughter) But his true claim to fame for today was that he was the founding executive director for PPRC, and PPRC moved through the period that we'll be talking about today under his leadership.

Next, we have Chip Kahn sitting next to Paul, president and CEO of the Federation of American Hospitals, but for today drawing on his experience as the staff director for the Subcommittee on Health of the House Ways and Means Committee during the deliberations over the Medicare Physician Payment Reform.

Then to try to move us through the Fee Schedule's implementation and on to the present we have Barbara Levy, vice president for Health Policy and Advocacy at the American Congress of Obstetricians and Gynecologists. And for six years, which I think is remarkable for any single human being, she chaired the American Medical Association's Relative Value Scale Update Committee, or the RUC, leaving that particular position at the end of 2015.

Finally, we have Mark Miller, the current executive director of MedPAC whose work encompasses both addressing issues with the Medicare Fee Schedule and the development and

implementation of alternative payment policies.

So, it really is a terrific group and I'm going to hand it over to you, Paul.

MR. GINSBURG: Thanks so much, Lauren, for that introduction. Bob and Lauren have filled you in on all the things that should have been said about the context but I was not planning to say, so they've really contributed to my talk. The initiative for the legislation that led to the Medicare Physician Fee Schedule really came from Congress. This was not something that came out of the administration. The administration was definitely engaged in the process, but in places like the Senate Finance Committee, the Committee on Ways and Means, the Committee on Energy and Commerce members were talking about these issues a lot in the mid-1980s. What was driving them were concerns about the imbalances in the fee structure that they were perceiving, or more likely various stakeholders brought to their attention, and they were particularly focused on this distinction between procedures and visits. They were concerned that Medicare was paying relatively too little for visits and too much for procedures. Particularly in the Senate there were serious concerns about the urban-rural dimension, about how much less Medicare was paying in rural areas than in urban areas. And this was done in an environment of deficit reduction.

The 1980s was a time of almost annual omnibus budget reconciliation legislation designed to meet a target for deficit reduction. What happened in 1984 is that that finally hit physician payments in Medicare where there was a freeze I think for a year. There were no updates in physician fees in the Medicare program. I think a lot of people started thinking if we have such an imbalance in our relative payments isn't the freeze or pressure on rates going to make it particularly problematic for the services that are underpaid, or if you look at the other side would such constraints with this imbalance actually limit the potential to save money in this area because you'd quickly run up against real problems for the relatively underpaid services.

The administration at the time was more concerned, they were very concerned, about excessive volume. They would like to have made Medicare spending a more predictable part of the budget and get some control over not just prices but overall spending.

So, the process. Basically, Congress issued a directive to the predecessor of CMS, HCFA, to fund a relative value study that turned out to be the study by Bill Hsiao and his colleagues at

Harvard and it created the Physician Payment Review Commission. Bill gave it a strikingly specific mandate, basically saying these are the issues we want recommendations on, this is what you should be working on.

There was a key piece of preliminary legislation that was passed as part of the 1987 budget reconciliation process that based on recommendations from the Commission Congress named "13 important procedures as overvalued and mandated reductions in the Medicare payment for those procedures." I say this was key preliminary legislation, it was almost like a test vote that if that could pass it showed the receptivity throughout Congress for more sweeping reform in physician payments.

So, what were the major design issues in creating this payment system? Well, one thing I would describe it as -- we didn't use those terms back then -- basically it was a science-based approach to set relative values. This was not an approach based on how much more should a surgeon earn than a primary care physician. This was an attempt to use science to determine what the relative values should be.

It involved measurement of physician work and practice expenses. The physician work involved time and also a concept called intensity. It was a very deliberate decision not to limit physician work to time. This may have been due to strongly held conceptual beliefs, it may also have been a political realism thing that the magnitude of redistribution if the Fee Schedule were strictly time-based probably would have been far too large for the legislation to ever have been enacted.

In a sense what this science-based approach was doing was simulating a hypothetical market, a working market, for physician services which obviously did not exist at the time. So instead of taking the cues from at the time dysfunctional physician services market it really created a series of relative values as to what a hypothetical market would result in. There was no attempt to specify either in absolute terms or in relative terms what physician incomes should be either over all or in different specialties.

There was an attempt to address volume that Bob Berenson mentioned before. Congress called it volume performance standards. I think the concept behind it, which did come for better or for worse out of the Physician Payment Review Commission, was to engage the leadership of the medical profession in addressing some of these volume issues. There was a lot of activity at the time,

development of practice guidelines, peer review was advancing. I think there was pretty broad recognition about the tragedy of the commons problems that this would not affect the incentives of individual physician practices for volume. So in a sense it was a broad challenge, an opportunity to the profession. My sense is that SGR, which obviously is looked down upon very poorly today, was really an attempt to push that idea too hard.

Another aspect of the reform was stringent limits on balanced billing which have not changed to date from where they came out of this legislation. This was a long-standing priority of the AARP, and also the balance billing limits reinforced the revised structure of fees.

Finally, there was how are the physician work values and practice expenses to be updated. A major priority of the American Medical Association which did support this reform was that they play a role as a convener of specialty societies to do these updates. So they envisioned the specialty societies working within the AMA rather than the specialty societies coming to CMS or Congress and lobbying.

In a sense I think what might have gotten lost in the process was that by working this out within the AMA the staff at CMS did not perceive it had a job to do which it would have had to do if they were making the decisions based on the direct lobbying.

So, early experience with reform. There was a substantial shift in resources towards payment for visits and away from procedures. I'm often surprised when I talk to younger physicians that this surprises them, that they just view it as, oh, yeah, they attempted to do something and it didn't work. But the data published by researchers at HCFA at the time showed very substantial shifts in resources away from procedures towards visits, away from procedural specialists and surgeons towards primary care and other specialties where much of their work involves visits with patients.

In my perception the shift was undone by an inadequate updating process over a period of 25 years. The volume performance standards, the attempt to address volume, did not blow up. It actually led to increases above the default in some years and below the default in other years. That didn't happen until the SGR in a sense made it a much more stringent policy.

What also surprised people a lot is the degree to which private insurers adopted the Medicare Relative Values Scale in their own payments, and of course they chose their own conversion

factor. But this actually greatly facilitated for them negotiation of payment rates with physicians. It was one number they could discuss; what percentage of Medicare is the payment going to be. Medicaid programs also adopted this very readily but that was not a surprise.

I would say that over the years there has been fairly limited or very little congressional micromanagements of this. This doesn't mean that Congress isn't quite concerned today about what they see as significant payment distortions, and Congress has taken some steps to reduce extreme overpayments such as advanced imaging which they did many years, and in recent years have issued directives to CMS to more vigorously address current distortions, to put more resources into updating the relative values, but the response has not been very good. Thank you very much. (Applause)

MR. KAHN: Good morning. I want to express my appreciation to Paul for asking me to come this morning. I appreciate the introduction. My purpose today, my assignment, is to speak about the genesis of the legislation of the Medicare physician payment reform.

I'd like to qualify my remarks first by stressing that I will be commenting looking back through the prism of time, obviously a lot has happened since the 1980s, and stress that my observations are impressionistic. And my apologies to anyone who questions my I'm sure revisionism in terms of telling the story. I'll try to provide some color as we go through my story.

Let me also say that at the time of '86 to for me '93 period I was the minority health counsel on the Ways and Means Committee primarily working for Bill Gradison who was the ranking member on the Health Subcommittee, Pete Stark obviously was the chairman on Ways and Means Health Subcommittee. And then in my next iteration on Capitol Hill I was staff director and you can partly blame the SGR and the final spread of perspective payment which Bob talked about on me, for better or worse. We'll see how you feel when I finish about whether it's better or worse.

So, how did this all get started? Well, I think without going into too much history the defeat of Carter cost containment began a process of reexamination. I didn't work for hospitals then but hospitals got away with a voluntary effort and beat Carter cost containment, and then everybody's hands were up in the air because there was still a problem. So when we got to the period of Reagan we had the advent away from trying to change the whole system and a focus on Medicare, primarily from I think the administration it was concerned about cost but there also was I think worry about the value proposition

and quality.

So, that began a process that I think surprised everyone in 1983. There was some earlier legislation that actually led to the '83 Social Security Act amendments whose last provisions were the DRG provisions. Actually, those provisions were put last in the bill because the Ways and Means Committee and Finance Committee staff working on them thought they would be chopped off in conference but they weren’t. And I think that began a process. Physician payment reforms roots are in the DRG system even though obviously the DRG system itself is a much different system.

But I think that the passage of DRGs created an energy, and we can call it either an aspiration, I think more now looking in retrospect a conceit, that we could drive change through Medicare and that we could use new methodologies to use the economics of payment to change provider and clinician behavior. That's what it was all about and that's what in a sense DRGs proved. And frankly of all the programs in perspective payment maybe the DRGs are the only one that we can look at over how many years and say, well, at least that worked. (Laughter) So, what came out of this was what I'll call a reform imperative, and in some cases I think it was almost anything that was a reform to the policy nicks was a good thing to do.

A couple of other things happened too that I think are very important. ProPAC, the Prospective Payment Assessment Commission, came out of the DRG legislation. Bob Hoyer, a Democratic Finance Committee staffer, didn't trust the Raegan administration and thought that Congress needed its own policy advisory group, and in this case it was just to advise them on the process of the development of the DRGs over time. But there is a direct link between that and in COBRA 1985 when Congress in its wisdom came back and said ProPAC is working so well with Stuart Altman and Don Young and everyone over there that we now want to invent another agency -- this was the Physician Payment Review Commission -- that would actually help us implement new policy, not just go back and oversee current policy. So, that's where PPRC came from.

So three things came together. Paul really described them. One was HCFA's effort to fund Bill Hsiao in the development of the resource-based value scale, the other was all the work described with PPRC, and then the other were the facts on the ground which Paul referred to: 14 percent Part B growth and a lack of assent of balance in the program, not enough emphasis on primary care, and

maybe too much incentive for procedures. In a sense we didn't call it coordination integration and somewhat different maybe, but really basically the same issues we deal with today.

So, that drove the imperative for this policy development that led to the process that Paul and Bob began to describe this morning. In the 1989 bill things got going, all the groundwork was done by PPRC for the RBRVS aspect of it, but as Paul described, you know, what's Medicare spending, whether it's Part A or Part B or healthcare spending generally it's price times volume.

PPRC did work on the volume side but clearly here I think the central character is Pete Stark and his staff because Pete made sure there was sort of this synergy or connection at the hip between his staff and Filee and Paul and Lauren. In those days -- and I don't think it's as true today with MedPAC, not that there isn't communication between the staff and the Commission -- I think back then the Commissions worked very, very closely with staff. So, I would say whereas with the RBRVS there was a tremendous amount of energy from many quarters, on the issue of volume I think at least at the get-go it was Pete Stark, Pete Stark, and Peter Stark. He wanted expenditure targets. And on the one hand I think there was a lot of flowery notions about doctors being able to get together and do the right thing, but I think from Stark's standpoint he just wanted to make sure they didn't do too much because he was worried about the aspects of constraining fees through the RBRVS.

So, in the action you had the Energy and Commerce Committee in the House -- as you know we have split jurisdiction in the House in Part B between Energy and Commerce and Ways and Means. They did the straight RBRVS and physician reform, we at Ways and means did RBRVS plus expenditure targets. The Finance Committee in its wisdom did RBRVS and I'd say expenditure targets -- they called them something different -- light. And then we went to conference. All these provisions were in the bill that went to conference.

The RBRVS was fairly common between the bills and had been staffed by PPRC so that was the easy part of it. There was controversy over whether or not there would be expenditure targets in the final bill. I think at one point Mr. Waxman who was Health Subcommittee chairman on the Energy and Commerce Committee and his staff thought there would at least be expenditure targets light if they would even be in there, and there was an agreement to that.

And then in the middle of the night when the big reconciliation bill was being finally

considered Mr. Rostenkowski got together with Senator Benson, chairman of the Finance Committee, and some magic happened and the more stringent volume performance standards were adopted. I'll never forget that sort of the morning after I went over to leg counsel for the final drafting of the legislation before it was going to go to the floor and I think in my experience I'd rarely seen Health staffers cry. And I won't mention any names. But when I went over there, there were all these Energy and Commerce -- there was actually more than one -- Energy and Commerce staffers literally crying because they thought that the Ways and Means Committee -- and they didn't blame me because I was just a Republican on Ways and Means, so they thought I was blameless. They looked at me and said, "Do you know what they've done?" I said no, what have they done? They said, "Wendell Primus got together and pushed Roste and they did this." So we got the more stringent targets. More about that later because I had more fun with that in 1997. (Laughter)

So, that was the creation of the Bill and it went forward. As Paul described, I think the MVPS either worked well or was very soft and did not have much bang over the years. After '92 and implementation you still had relatively large growth in Part B. And I'll conclude with this to the end of the story which I guess is maybe the beginning of the real tragedy of physician payment reform, that was when I was staff director on the Health Subcommittee and we had a very stringent mandate about how much money we had to save in BBA '97. I won't get into the details of BBA '95 but most of the roots of '97 were in '95 where we had really big targets to meet.

So, that was where the sustainable growth rates came from. A combination of we still had tremendous growth in Part B that was as we always said "unsustainable", and two the need for budget constrain, and that led to SGR and we all know what happened after that. Fortunately, we now have MACRA and no longer have SGR. But clearly at least from my perspective whatever it was supposed to achieve on the constraint side that didn't work out very well. And I think we heard from Paul that on the RBRVS side there may have been some effect early on but it was a difficult thing to hold over 25 years. So with that I'll pass the baton. (Applause)

MS. LEVY: So, on the AMA side we were looking at all of this and saying who is going to adjudicate all of this and how are we going to decide who does what and how and why? In 1992 the AMA came out with the RBRVS Update Committee. Just a little background on coding so you understand what

the background for all of this is. We basically have code sets that define where these RVUs are allocated. There are procedural codes, the CPT codes, and there are then justification codes, ICD-9 and now ICD-10 that describe why you did what you did. But the RVUs are assigned two codes. There are about 7,000 codes in CPT; that's a little bit of work to do to decide how are you going to allocate across 7,000 codes.

So, the AMA convened an expert panel. This was never supposed to be a panel equally representing the world, it was supposed to be a panel of specialty societies that could in a zero-sum game sit around a table and some would win and some would lose, but that using their expertise in medicine and the science of medicine could adjudicate the allocation of RVUs. That is not a straightforward task. Intensity is in the eye of the beholder. And we learned very early that some surgical specialties would come and sit before the table and talk about families and people dying and all of those things, and others would come in and talk about but this demented patient sitting in front of me and it's terrible and I have to deal with the family. And the science of the psychology of intensity was quite interesting. (Laughter) I'll just leave it at that.

I have survived six years as Chair of the RUC. Maybe if we became a little bit more collaborative, but we also came up with some systems that would help us look at those things and make some sense out of it.

So, the RUC has been making recommendations since 1992. The data are collected by the specialty societies both for time and for some measures of intensity, but then they are presented to this Committee of the whole and have to be defended. That was really the new thing that the RUC brought to this process was a defense of the proposed RVUs for work around a table of peers and getting to some consensus by the end of a meeting which was not all that easy to do.

The RUC process has over 100 specialty societies with advisors that are there. The voting members of the RUC are now 31, started out at 29. There are also representatives for ancillary medical professions that are represented in the Fee Schedule.

But as we've already been talking about there are some real problems with the RBRVS, and it is peace work. It is payment for volume, and whether that's payment for how many patients you can rush into your office all day or payment for how many open-heart surgeries you can do it is still peace

work.

There are some other interesting things that I've always found from a policy standpoint to be very disturbing. In RBRVS we pay a physician one day out of training exactly the same as we pay someone with 30 years of experience and proven outcomes. There is no other profession about which I'm aware where the fees are the same, whether professionals don't have to demonstrate some outcome to prove their value. Reputation, experience, collaboration with others, so it's kind of interesting.

But also what's happened over the last many years since 1992 is a real change in industry. We have all kinds of ways of managing things now that we didn't have before. We have pharma pushing medications that add to the cost in the Part B system because some of those drugs are in Part B. We have a lot of equipment and changes. We've gone from cardiac surgery to interventional cardiology and trying to take all those new codes and assign RVUs to them has been a real challenge, assigning those relative values particularly when things start out as very difficult because they're new and how do we look at them five years later, ten years later, and adjust the values for those things.

So, a couple of things that have happened over the years with the RUC. We've added seats for geriatrics and for primary care to make sure that that voice is well-heard, and there's a lot more transparency to the process which I think has also been really important. One of the big hazards with RBRVS was the mandated update, the five-year review. And for the first three five-year reviews at that time HCFA and then CMS relied upon public comment to bring forward codes that were potentially mis-valued. So, occasionally a private payer would recognize that a set of services was overvalued, but in general what would medical specialty societies do? They would fight for codes that were undervalued in the system but no specialty society would make a comment to CMS to say please reduce the payment for me and my members for this particular code. Because the specialty societies were paying to play, they were paying to send people to the RUC.

So, over the first three five-year reviews what we saw was escalating costs and a redistribution, as Dr. Ginsburg said, of some of those dollars back into the interventional specialties. Just after the third five-year review, and having listened to Mr. Miller and a lot of commentary, the House of Medicine got together and said, okay, we need to do this. The RUC took on the task of identifying potentially mis-valued services.

A huge undertaking, a very, very difficult vote around the RUC. I was chair at the time, Bill Rich had set it up for me so he had done a great job. But the RUC took on that task and the AMA staff put together screens so that we could begin to very fairly and reasonably look at potentially mis-valued services. Over the years 1,700 out of the 7,000 services have been assessed as potentially mis-valued, 1,300 of them have been reviewed, and it has redistributed back about $38 billion in Medicare.

So, it was a contentious process, it continues to be a difficult process. The specialty societies, and I represent one, are not happy about having to resurvey codes that are nicely paid and take cuts, but that's what's been happening over many years.

The other thing that's sort of an unintended consequence of RBRVS is on the practice expense side, it's the difference in payment between the same procedure performed in a facility and a non-facility. That just highlights for you the difference in a new patient complex service when provided in a physician's office at about $200 versus in a hospital or a hospital-employed physician who is same physician, same practice. Last year I was private practice, this year my practice is owned by a hospital and the payment is $130 more for the same service.

Now, the physician payment is no different, the work RVU is the same. What's different is the practice expense. And that's an unintended consequence of RBRVS. There were reasons for all of this. But as we've seen consolidation and we've seen the number of physicians become employed by hospital systems -- and large systems and this is just a graph to show you that somewhere around 60, 70 percent of physicians and my understanding from the College of Physician's is up to 80 percent of newly trained internal medicine physicians are hospital-employed or employed by large systems, that adds a cost to the system that is not allocated to the physician. So, it's an unintended consequence of the demarcation between practice expense and work RVUs.

So, where are we? I think that the RUC has done a lot to update the process over the last six to eight years, there has been a lot of change and reallocation, and the AMA RUC and the specialty societies have taken on the burden of revisiting codes and revaluing services, bundling codes together. It's been a big burden for CPT as well because one of the screens is things that you always do at the same time together and bundling those together and taking account of the resource allocation, which there is overlap when things are done at the same time.

So, I don’t need to show you this slide that we're spending far more money in the U.S. than we can afford, we're spending four times what the next highest country spends and our outcomes are not better. But I'm not sure that the RBRVS is dead, I'm not sure that the input from the physician community should be lost. I do think that we have to go far beyond fee-for-volume and go to a value-based system, but even within a value-based system we have to adjudicate in some way how we pay for providers.

So, I do think that there is a role for an organization like the RUC where the specialties can sit around together and work on those things. I think current resources may or may not be applicable to all of the advance payment models that we're going to look at. But certainly continuing to adjust things over time is important. I think that we need to be flexible and understand that some innovations will be very valuable and some will not. But we live in a culture where our communities, our patients, want more and more and they want the latest and greatest. And that is far different -- we don't have systems in place in this country to put the brakes on some of those things, we don't have a NICE here in the U.S. that tells us, wait, we're not going to pay for those things until they're of proven value. So, those new technologies are a real challenge for us and something that RBRVS really can't address entirely.

So, is there a future for something like the RUC? The answer is yes, if you want to have a venue where the physicians and the providers are around the table talking about critical payment systems. I think it's yes because I think we need the voice and we need the support and we need the enthusiasm of the provider community to deliver better care at lower cost.

The last thing, something that's an unintended consequence but the RUC and CPT panels have really grown a lot of physician leaders who deeply understand these things. There are very few of us and we are really needed in order to help inform the process as it goes forward. (Applause)

MR. MILLER: I'd like to thank Paul and whoever else was involved in asking me here. I know it's always a risk so I appreciate you taking it. (Laughter) And Lauren and Katie for giving me guidance on what I should say and do. I guess to any young people in the audience who are listening to this and thinking it sounds really cool and they want to dedicate their career to it, don’t do it, it will break you. (Laughter) I used to be a really happy guy and now I'm not.

Okay, but seriously. So, all this has been said. I thought I had some really interesting

comments that everybody would go, oh, really? But everybody knew all this. So, the intent of the Fee Schedule was to reverse the charge-based mechanism that physicians were being paid. Physicians very quickly figured out if they raise their charges they got paid more and that was a bit of an issue.

The second thing that it was intended to do was correct this imbalance that had resulted through the charging practices where the procedural side and the cognitive side, or the procedural and the primary care side of payments were thought to be distorted. People also thought that urban and rural were off, which Paul said. And then as the process started to get cranked up people said that, well, we should also be looking at volume controls.

I think the Fee Schedule has probably failed on two counts. One, it has not rectified that balance, and two, it never really achieved any volume control in any consistent way that I think could be documented very well. The imbalance continues under the volume controls. I think the imbalance was actually accelerated because when you kind of add it to the process that was going on in the RUC, which Barbara went through and I thought did a very good job describing that, as well as the notion of generating new codes the procedural side of the Fee Schedule had the ability to do that, the new code would be created, it would get a high value but then it wouldn't necessarily be reevaluated over time as efficiencies were gained. Procedurals had greater opportunity to generate volume, and of course if there was any penalty to that it was borne by all physicians and not the physicians necessarily directly benefitting from it.

We believe that there continues to be an imbalance in the Fee Schedule. With the Urban Institute, Steve Zuckerman over here, we have documented regularly that there are sort of hourly and net compensation differences across the specialties that are quite large. And also with the University of Minnesota on very much a proof of concept type of basis, a very small scale, but I also know other people have done this, again the Urban Institute folks, Bob and Steve and some Rand folks have done this, been able to track real differences between the time physicians actually work and the time that is assumed in the service. And we believe that there is a distortion throughout the fee schedule, that the fee schedule assumes more time than it takes to deliver a service, but it is highly distorted at the procedural side of the Fee Schedule.

So, the Commission has made a number of recommendations, and what I'm going to do

now is just kind of go through some of those recommendations to try and address the process in this imbalance. I do want to say there is a huge change in physician payment which is MACRA, MIPS, and APMs, and I have things that I could say about that but what I think we'll try and do is do that on question. I was asked to talk about this portion of the Fee Schedule. But if anybody wants to get into that we can get into that too.

I was going to talk a bit about our views on the RUC process. Barbara did a very standup job in talking about the fact that it was creating distortions and it didn't work from the Commission's point of view very well. She did a very good job in sort of describing who is going to step forward and say actually I think this isn't priced right, I want you to take it down. So, a decade ago we were doing analysis, again this time with the Urban Institute, that was showing that the recommendations coming out of the RUC were to increase, increase, very few decreases, and CMS was just simply accepting those recommendations.

Change as a result of the attention and as a result of the tension between the RUC and MedPAC. The RUC has gone through changes, and again Barbara went through those. We do believe there is a role for the RUC but the RUC should be advisory, the responsibility for the Fee Schedule very much lies with the Secretary with HHS and should be managed by HHS. In fact recently there was a proposed rule that said HHS would defer 100 percent to the RUC recommendations and we very strongly said that that's the wrong direction to be going in.

We made a recommendation to actually create an executive branch advisory group for the Secretary comprised of physicians and nurses who don't have a direct financial relationship with the Fee Schedule to both help identify where distortions occur and to review the recommendations that come access the transom from the RUC.

We've also made a recommendation -- and actually the roots for this go all the way back to the legislation of identifying overpriced procedures -- we said that there should be a five-year period in which the Secretary identifies 1 percent of overpriced procedures each year and then reprograms those dollars because we expect to find them on the procedural side of the Fee Schedule to the cognitive or to the primary care side. I'm using the kind of 2010 ACA primary care definition which we can take on question. The Congress actually took up something like that. They did a smaller amount over a shorter

period of time, but our recommendation still is out there and we feel that there is probably more that needs to be done there.

Another recommendation we made was to have a direct 10 percent add-on to primary care services, again using the same definition that I've been using throughout there. And again, to reprogram dollars from the procedural side of the Fee Schedule and put it over on the primary care side. Congress did in fact peruse that. They did not do the reprogramming point, they spent new dollars, or deficit finance dollars, and financed the add-on but that add-on has since expired.

We've made another recommendation that there should be a primary care add-on but we made one change in that, and I think there is a structural point that I want to make here, we said that the add-on should go to the primary care physician using the definition that I've been using right along but that the payment should be on a per-patient basis rather than a per-service basis. So, the idea is to give the primary care physician some flexibility in terms of coordinating care, managing things by phone or email so that they don't have to get that revenue entirely through a visit. Some of the underlying thought behind that is that the Commission is starting to think that maybe the Fee Schedule is not well designed as it relates to primary care types of services but maybe well designed for more procedural types of things. So, that thought is embedded in that recommendation.

The last recommendation that I'll mention is that we think that there should be a different process for collecting data to determine what is overpriced in the fee schedule. So, what we've said is that, again, this pivots off what I said a few minutes ago where you can do analyses that suggest very strongly that the time a physician actually works versus the time that's assumed in the Fee Schedule is generally higher than the time worked by the physician.

So, the recommendation goes to this, which is CMS should identify standing practices and pay those practices in order to collect data for them on two or three data points: the time the physician works, the services provided, which services are provided, and the volume of those services. Then you can use regression analysis and it will point to the services where the time distortion is quite high, and then either the Secretary could administratively choose to take the value of those services down or ship that information to the RUC and say we believe these services are overpriced, please consider them, that type of thing.

So, that's what I have by way of comments and I'm going to stop, expect I'm going to mention the other thing that Barbara brought up was the difference in getting paid for the same service, a couple hundred dollars difference in the hospital setting versus the physician's office setting. I won't say anything more about it other than to say we've also made some recommendations there. (Laughter) If anybody would like to talk about those, but then Chip is going to have something to say about that. (Laughter) Since I can't get back to my seat I'm just going to go out the door. (Applause)

MS. LEROY: Thanks very much, Mark, and to all of you. Before we open it up for questions I want to start by giving the various panelists an opportunity to react to what they've heard or if there is something you now realize you absolutely forgot to mention to bring it up.

MS. LEVY: Let me just throw out something that's even much more difficult for us to think about, and that's market forces. But when we look at time we're looking at time per procedure, we're not looking at on-call time or responsibility. So let's say there are two neurosurgeons in a community who are responsible for the entire hospital all the time versus we have hospitalists and primary care docs who get to choose their hours to some extent, and I'm not downplaying the on-call, but we do have an issue with how many years of training, what's the opportunity cost for that level of training, and then what's the responsibility for some of those higher-paid specialties and how are we going to account for that. If we get scientifically down to the minute of how many minutes a procedure takes and we don't count non face-to-face time, so we don't count the phone calls from the ICU all night, we don’t count some of those things, how are we going to bring that into our system?

MR. KAHN: I'd just like to say one surprising outcome of this for me was that post-1983 private insurance companies generally did not adopt the DRGs, they got value I think from the effect of the DRGs on length of stay, but they stayed with per diems and negotiated those over time. Whereas on the physician side there was a lot more adoption of the Medicare -- they might have had a different multiplier, but a lot more adoption of the Medicare Fee Schedule. So, I think the Medicare Fee Schedule in some ways in terms of the total system has had a very large impact way beyond Medicare. Now, you could argue DRGs have two but as a system it didn't get adopted.

So, I think it's also noteworthy that as much as we lament it, it is a fundamental in the way both the private sector operates generally because we can kid ourselves about all the wonderful

alternatives there are out there, we still are basically a fee-for-service system.

MR. GINSBURG: The comments that Barbara Levy and Chip Kahn made gave me an idea. Barbara said market forces, and I just wanted to point out that when we go beyond Medicare into private payers another thing that is driving the relative values away from what science would call for is the fact that many procedural specialists have more market power because of the practices they're in, they tend to be a larger part of the pool in that community. The research I've done on this shows that they're a very significant pattern of divergence from the Medicare pattern with private payers.

MS. LEROY: I found interesting one comment that you made, Barbara, about the fact that the current relative values may or may not reflect the appropriate allocations of resources and practice expenses for new models of practice, team-based models. I wonder if you can elaborate a little bit on that and whether others can response or sort of react to the implications of that observation going forward in terms of how we're going to address that given the problems that we've had to date even trying to keep the relative value scale as it is now updated.

MS. LEVY: Sure. Let's talk about care coordination. That requires clinical staff and staff that would not be allocated to individual CPT codes. So, part of the issue is that we need to create new codes that describe work in an advanced payment model and the RUC and CPT are working together to do those things. Several years ago, probably ten at this point, with medical home there was an effort to establish a prospective payment system for primary care medical home and there was a large expenditure by CMS to a contractor to try to price that unsuccessfully. The RUC was able to do it, but it took a lot of work.

So, I do think that there are a lot of services that practices have always done ancillary to RBRVS, care coordination, phone calls, non-face-to-face, trying to manage patients to keep them out of the hospital, to really reduce the total cost of care that needed to be accounted for in some way. We need either new codes or new systems or a totally per-patient-per-month payment system to be able to account for all of that, but we need to know what the elements are to get the right number.

MS. LEROY: Any reactions? Mark?

MR. MILLER: Well, I may not follow entirely what the question is, but to what you were saying at the end of what you ticked through I would probably not urge us to go in and start trying to find

codes as opposed to more of your PMPM idea at the end and say if you're going to make a payment make a payment then let the clinicians figure out within that the best way to organize their time and their structure knowing that they have some kind of payment boundary.

MS. LEVY: The only reason to create codes is to agree among us what the carve-outs are. So, PMPM as a universal but everybody is always going to want, yes, but there's a carve-out for cancer, there's a carve-out for this or that. I think there is some purpose in crafting -- for example, would the PMPM be the same for a 65-year old with very few underlying conditions versus an 85-year old geriatric demented patient?

MR. MILLER: Again, the way I think about that is -- and again, depending on what size unit and all of that, there are a lot of things here that are being assumed, I would say yes, I agree with you that you might adjust the PMPM on the basis of the complexity of the patient, the condition of the patient. But what I think starts happening, and this happens a lot when you get into the physician and Physician Fee Schedule world, is you're carve-out comment. Each of them steps forward and says, yeah, I'm into this but I'm special and I need this. Then when you have hundreds of specialties and thousands of services -- I mean look at the quality measurement process right now and where MIP stands in that, and it is really a product of everybody saying you have to measure my specific thing. I do a left-handed surgery only and this is what you have to measure. I think as long as both the payment on quality kind of drive down those types of paths we will constantly be in these conversations. I tend to think of it going in the other direction and get less definitive but put more of the responsibility in the hands of the clinician and say here it is, manage it.

MS. LEVY: I think that works if we're employed by large systems and the systems can take care of all of those things. I think it's more problematic in non-urban settings where you have individuals who are unable to do the total care of a patient. I'm not disagreeing with you because I think from a policy standpoint that's where it needs to be, at a much higher level than it is. And I think there is much more resources utilization in urban settings where there are way too many specialists and too many consultations and too many things going on. But I do think we need to have some agreement on what that PMPM payment covers and what it doesn't. And to the extent that we have that agreement that would be some sort of a code or some sort of a way of reporting what it is we're doing.

MS. LEROY: Chip, back in 1989 were there some in Congress who had different ideas that were put out on the table that you think would be instructive today for how to deal with spending or with the differentials among different specialties in terms of payments and the values for their services or did most line up behind the Medicare Fee Schedule pretty quickly?

MR. KAHN: I'm glad you asked that question. (Laughter) I mentioned this sort of notion I have which is the reform imperative. I think probably 99 percent of the policymakers, the staff, and the advisors to Congress in the '89 Act which was sort of the culmination of all the work that's been described thought we needed to make the big change because we had the methodology -- Bill Hsiao had done all this work, I believe it was on Medicaid in Massachusetts or wherever it was -- and this is what we have to do.

I would assert that -- and we suffered from this disease even in '97, and actually in '97 it was worse because there we didn't even have methodologies, we just put language in there saying we've got to go prospective payment for home health and some other things to sort of clear out all the areas that didn't have a mythology.

I think there was this notion to drive, which in retrospect -- and I guess I am sort of conservative in that way -- I wonder whether if we had made just minor adjustments to the existing reasonable and customary whether we could have avoided a lot of history. There were, myself and two other people that will go unnamed, who pled with members to think, well, gee, do we really need to do this? If this is really all about the imbalances then we've been arbitrary in other things, why can't we just be arbitrary in some of these codes and then see how it plays out rather than moving to an entire system which is based on these RVUs that are still conversational? Any real research on this is almost impossible because time in motion studies -- actually it's a moving crap game because what a physician does one day with a procedure may not be what they do six months later because even though they may not change completely they're constantly evolving. So, the time in motion one day is not necessary relevant 24 months later. So, we question just the whole notion but frankly no one listened.

MS. LEROY: Paul, let's see if you're going to say what I was going to say.

MR. GINSBURG: In response, I remember that Bill Roper when he was administrator of HCFA at the time was very vocal about not wanting to put the energy into the Fee Schedule because the

solution for Medicare was capitation. I was always baffled when he would say that because I didn't think he had a capitation proposal in his back pocket. And 25 years later what have we done about capitation? Well, we do have accountable care organizations which do use concepts from capitation but it's entirely based on the Fee Schedule. And I guess this is later in the afternoon so the degree that the Fee Schedule is distorted it could be a problem for ACOs.

MR. KAHN: This is an interesting question because now that you bring it up I do remember Bill's arguments at the time, and I think the same thing happened in ACA because the focus was on ACOs and that notion and not on bundling. I would argue that in retrospect it would have been better for Medicare to spend it's time -- not sure all my employers would think about it this way -- but they should have focused on the bundling side and not spend all this energy on this unproven concept which I think frankly if you're going to do managed care let's do managed care. I think with respect to the Democrats in the room, I think Democrats tend to be allergic to insurance companies and they wanted this thing called ACO to do what supposedly insurance companies are supposed to do if they have a value proposition. Maybe they're not doing it.

And actually going back to Bill's -- I forgot that Bill Roper had said that. Maybe if we had put more energy into capitation back then we would have had a different future. But it is what it is.

MS. LEROY: Let me open it up to the audience. Do we have microphones? Okay. Question right here.

QUESTIONER: I'm Dr. Caroline Poplin, I'm a primary care physician and an attorney and a columnist for MedPage but not an economist. My understanding is that in Economics 101 if you pay too much for something you will get too much of it, and if you pay nothing for something like no money for telephone calls, no money to talk to the family, you will get not enough of it. I don't understand why you don't incorporate this. If you think we're doing too many knee arthroscopies or back surgeries you need to reduce the price and people will not spend an extra four years learning how to do it if it doesn't make them that much more money.

MR. GINSBURG: I can answer that. Because at the time that this legislation was contemplated those arguments were made very strongly. In a sense what might have motivated members of Congress were issues about fairness to different stakeholders but it was very visible and a lot

of it came from the Commission about this is distorting -- this is making fee-for-service worse so it is garnering more procedures that we already have too many of. And that still holds as you say. I'm convinced that the Medicare Fee Schedule with its restructuring of payment helps on that dimension and to the degree that it has not been maintained the issue is with us again.

MS. LEROY: Yes?

QUESTIONER: My question relates to possible unintended or intended consequences. You are all too young to be receiving explanations of benefits for office visits to physicians under Medicare Part B. If you received those you would see that Schaeffer Urban Hospital Primary Care might bill something at $900 but its Medicare Schedule is a reimbursement schedule, so then you will see that Medicare is reimbursing Schaeffer Urban Primary Care at $150 and that Schaeffer Care agrees to forgo the other $750, if you follow my example.

So, they're billing at X rate, they're being reimbursed by Medicare Part B at a significantly lower rate. My question is, is it the uninsured that are actually paying the $900 rate and does that effectively mean that the uninsured are subsidizing the Medicare Part B? So, point out the flaws in that. Thank you.

MS. LEVY: I'll answer from a private practice standpoint having dealt with 650 different insurance companies to manage my patient population. The reason for that disconnect to some extent is that the private insurers some of them are still paying discounted fee-for-service, so people will pick a number and get paid a certain percentage of it by BlueCross BlueShield, for example, where they might not from Medicare. But you're absolutely right that the people who pay that outrageous full price are the people who are uninsured, the people who have sometimes large deductibles or contracts with their third-party payers that allow for balance billing or there's a practice that, for example, doesn't have a contract with BlueCross BlueShield, so I will hand you a bill, you can send it in and get paid from BlueCross BlueShield but you owe me the difference, the balance bill. So, yes, major problem.

MR. KAHN: So, in the hospital the private payers generally -- in the outpatient context as well as the in -- pay more that they have negotiated than Medicare or Medicaid does, and the uninsured person at least in the hospitals that I work for are generally offered a discount and generally pay nothing. So, the uninsured person in the hospital emergency room is not paying for the services and the private

covered people, BlueCross or whatever plan, there is a cross-subsidization now that we can get into a debate over whether there is cost-shifting or not. And we will. (Laughter)

MS. LEVY: And I'm not sure that I agree that that private person is not paying. If they have no money and they're totally destitute then they're not paying. But if they've chosen not to have insurance and they have means they will pay.

MR. KAHN: Well, first there are very few people that fit that category at least in terms of the hospital context. And frankly, I can tell you in terms of our bad debt as well as the charity care that a very small percentage of the uninsured are paying anything and the only people that are paying full charges if they even do is the random sheik that comes from Saudi Arabia, frankly.

QUESTIONER: -- to Part B because it's office visit even if it's office visit for a primary practice for instance that's affiliated with the hospital, it's still Part B not Part A. So, I was asking about the full price under Part B. I just think your answer was more directed at something being done under Medicare Part A.

MR. KAHN: No, no. I was speaking about Part B, and the emergency room is almost all Part B.

MS. LEROY: We have Katie here, Bruce, and this gentleman here.

QUESTIONER: One of the things I think Paul mentioned on the reform early on was -- maybe Lauren, I don't remember -- there was several parts to it, there was rationalizing payments, beneficiary liability protection, and also one of you made a passing comment to providing better information to physicians about good processes of care. And it's when AHCPR was created as part of this whole portfolio and the logic at the time was we'll do better research and we'll write down really great clinical guidelines. In the long run the fantasy was we could even maybe tie Medicare coverage decisions to evidence-based treatment, right? That was sort of -- I don’t know if you remember, that was a long time ago. That ship sailed, it didn’t really play out that way.

But one of the things that has sort of always stymied those conversations was that the first sentence in the Medicare legislation is no part of this legislation shall be taken to say that the government is telling doctors how to practice medicine, like that's the first sentence. So, every time in my experience watching this over 25 years there is talk about linking payment to information about what's

good clinical care or whatever that sentence gets pulled out. It's written down, it's a real sentence. I'm just curious if you guys have any thoughts about the importance of could that guideline thing have made a difference, is there some missing opportunity to provide better information, and is it ever going to be feasible to link payment to information about what's quote unquote good care?

MR. MILLER: My response to that, if I follow your question, is I think where does that information come from, how frequently is it updated, who agrees to it, and again, with all respect physicians will start to say no, no, no. And you'll also get a lot of the kind of finger pointing between specialty societies because they are not as siloed as everything is, they are not entirely, two different specialties can be involved.

So, you can pursue those kinds of approaches, again if I'm following your question. But again, if you can get payment to be more structured upfront, whether it's a PMPM or an ACO -- and I do think there are ways to overcome rural problems, I think the federal government or Medicare just has to realize there will be subsidies in rural areas and you just need to target them and pay them well, which not doing that right now but there will be a way to get around that, and then leave the decision-making to the clinician at the point of contact as opposed to the guidelines, again, if I follow your question.

I think you can wrap around that with things like trying to measure on a population and outcome basis stuff you don't want to happen like going to the hospital, like going to an emergency room. I also think you can wrap around that and potentially if there is absolutely clear evidence and you can have people come together and say, well, there's choosing wisely these are low-value services, you could bring that into bear. And it's almost like here's a space and then you manage around the space as opposed to I'll be in the space and you do these types of things, it's sort of the way I think about it.

MR. KAHN: I think it's partly money. I think that when AHCPR was originally formed -- and I was one of the people that drafted the legislation with Peter Bedetty which took the various agencies and put them together -- I mean, we had a notion of the function and this was one of the primary activities and everybody remembers I think it was the back surgeons and their initiative and it didn't go well. There was then an axis that formed between those kinds of people and the people that I used to work for -- a number of Republicans and probably the current Secretary too over time, I'm sure he's sympathetic with that -- I think impeded just the funding. So if you look at it today it's pitiful. I mean, with

all due respect it's a shell of what our aspiration was, not even a shell.

So, I think part of it is that we've failed over the years -- not that there aren't all these measures out there -- but we've failed to really fund and nurture that enterprise so that it could actually support the efforts we're talking about. So, I think the only salvation now is that looking into the future we now have the ability to use big data in ways we never have before, and maybe the computers will solve the problem in terms of allowing us to both create the knowledge to determine what the right way to practice is and then something that's dynamic because it can constantly readjust itself.

MS. LEROY: I'm going to stop this just so we can get these last two questions in because if we look at the clock we're going to run out of time and I want to make sure we get to them. Bruce and right here.

QUESTIONER: Bruce Steinwall, I'm a semi-retired health economist and a member of the Physician-Focused Payment Model Technical Advisory Committee, also known as PTAC. It took six months to learn how to say that. (Laughter)

First of all thanks for this. I mean, as someone who lived through the years that we're talking about here I just am so pleased to be reliving those years despite what Mark Miller said to the young people in the room. (Laughter) And you know how memory is selective. You don't remember the long weekends that never went anywhere, you remember the excitement of being involved in the policy process.

So, I want to ask a question I know is going to be addressed in the next panel but by different people, and I think I hear both sides of an answer to the question I'm about to ask so I wondered if you'd answer it directly. I'm not sure who to attribute this statement to, "You have to fix the Physician Fee Schedule before you can get rid of it," but it could be Bob Berenson, it could be someone else, it could be somebody on the panel, I don't know. But in any case, I think I hear both sides of the response to that question and I wondered if you'd be willing to address it directly to establish a baseline for the next panel that comes forward.

MS. LEROY: Since the next panel will be talking about this let's try to be brief so we can get our last question in.

MR. MILLER: What are you looking at me for? I wasn't bothering anyone. (Laughter)

So, I guess just in terms of practicalities and getting things done and moving ahead I think you could probably keep the underlying structure of the Fee Schedule with changes. What I was trying to say is that there's probably a different way to go at primary care and maybe cognitive more broadly and pay a bit differently but still keep some of the fundamental structure of the Fee Schedule and then build around that this notion that we've said to each other a couple of times, can you define payment that allows flexibility within that? You're either removing all the way out to managing care of even if you stay on a fee-for-service platform.

MR. KAHN: I think Barbara described how when you go to the next step, whatever the next great payment in the sky is, you're still going to have to have a basis for it and so we're stuck with fee-for-service. So, we've got to make it as accurate or as market-oriented or whatever as possible because at the end of the day it's going to be the basis that we create the capitation or the payment amount from. We don't have anything else. That's what we did in DRGs and it's actually worked pretty well. I mean, it was cost basis back when, when we all were young.

MR. GINSBURG: Just to add to what Chip is saying, whether it's a matter of just for benchmarks or for shared savings, if you have distortions in the foundation the structure you build is going to have problems.

QUESTIONER: My name is John Goodson and I'm a practicing primary care internist in Boston but I'm also the Chair of the Cognitive Care Alliance. We spent a lot of time talking about valuations but we haven't really talked about service code definitions. Bill Hsiao identified this at the get-go, we spent a lot of time talking about some of the differences in valuations that have evolved over time. But there is a fundamental problem with the definitions of the E & M service codes that have plagued the system from the very beginning and it's not been addressed. I'd like the members of the panel to take a moment and just think about that major problem, that there's been a huge change in what I call the topology of evaluation and management services.

The reason my organization exists is because as a common ground between all of us who practice cognitive specialties, that's primary care and others including rheumatology and infectious disease, et cetera. It's not just primary care that's tanking, it's a broad range of cognitive specialties. My father, a physician, said that he had two sons who had gone into medicine, one was a surgeon and one

was a physician. We have two different worlds here that we're trying to merge and I think we need to go back to some of the fundamental thinking and we need to go back and be sure that the E & M service codes are appropriately defined and valued. Valuation is extremely important but definition is even more fundamental.

MS. LEVY: I'll just say that my point about having to create new codes was exactly directed to that, John. I mean, there's no question that there is a lot of work that's being done that's not captured in the current coding system, and I think that that work needs to be recognizes and I think that in the coding system we need to create codes that include and value that work.

MR. GINSBURG: The counterpart of the need to bring the valuations of procedures up to date reflect current technology. The counterpart in valuation management services is the need to evolve the coding to reflect changes in the practice of medicine.

MS. LEROY: Clearly we've been talking here about both the need to make corrections in the current Fee Schedule but also the challenges of the updating process. Even if we did the work and had what looked like it was much more accurately developed over time it could again become distorted, so those two things go hand in hand.

I want to thank the panel. Can you join me in thanking them? (Applause)

MR. BERENSON: Okay. For this session, we have a collection of physicians who have both been clinical -- clinical for many years. Two of whom have served on the ROC, but all are very involved with inventing, developing, trying to implement alternative payment models. So have had one foot in APMs and one foot in traditional fee scheduled base payment. We thought it would be useful to have a panel that ascribed, discussed the interactions between the fee schedule. To what extent the fee schedule serves as an impediment to trying to accomplish value-based payment; to what extent does it support it; and can it be improved to even be more supportive?

The plan here is for each of the panelists -- basically, what the rule was, say whatever you want that's relevant to this topic of interaction to make the point you want to make. You have five to seven minutes, or actually the timekeeper's going to say five and we want to keep those comments to targeted. And then I have a series of questions that if the speakers do not address them in their presentations, then I will go down the line and ask very pointed questions about the interaction of the fee

schedule and APMs. So that is the plan.

It's important for you to understand who's here. You all have bios, I just want to emphasize just a couple of sentences about each one starting from my immediate right, Mai Pham who is an internist, is the vice president of Provider Alignment Solutions at Anthem and is working there with the new payment models to produce value. But significantly, prior to joining Anthem in 2017, Mai was the founding official at CMMI where she served as chief innovation officer and was responsible for implementation of a range of alternative payment models under -- under what became MACRA before and subsequent to the passage of MACRA. So, she has had a broad view of APMs.

The next will be Simeon Schwartz, who is the CEO of Westmed Practice Partners. It's a medical group in Westchester that was formed in 1996, a multi-specialty group which now has over 350 physicians, 14 locations in Westchester County and for the last, what, 12 to 18 months, you've been serving as Optum Practice Partners of Physician Management Services Company which was formed in 2011 and acquired by Optum. But basically, Simeon has been based in London and has been looking at payment models in the U.K. and delivery models in the U.K. as part of that activity.

The next -- down the line is Frank Opelka, who's a surgeon -- oh, I should say Simeon is an oncologist and practiced many years, oncology. Frank Opelka is a general surgeon, is that right -- colorectal surgeon who is the medical director for quality and health policy at the American College of Surgeons. He has been the physician executive at a couple of academic healthcare centers. And most recently, is responsible for as one of the leaders of developing a very ambitious payment model to pay a significant percentage of Medicare dollars in the form of bundled episodes for procedures and moving on towards paying for conditions. It's a joint ACS-Brandeis University payment model that has been reviewed by the physician focus payment model technical advisory committee as one of PTAC's first models that have been reviewed. He served -- he was telling me, 15 years on the ROC, so he has that perspective as well and suffers from PTSD (laughter) which he commented to me as he heard the first panel's presentation.

Next in line is Grace Terrell, who's an internist, who's currently the chief executive officer in vision genomics, but prior to that, she launched chess, a population health management company dedicated to helping health systems and other medical groups make the transition to value-based

medicines and for over 16 years, she served as president and CEO of Cornerstone Healthcare. A 370 provider, independent, multispecialty group practice that is active in North Carolina.

And finally, Allen Lazaroff, who is a geriatrician. He's practiced geriatric medicine for -- since 1978. He founded the second largest PACE program in the United States. Served on his board for nineteen years and has been very involved with an organization called Physician Health Partners, which mostly has been paid through capitation include Medicare Advantage plans in the Denver area and has been involved with Pioneer, ACO and MSSP efforts, shared saving models. He's also on the American Geriatric Society; has been the member from the American Geriatric Society on the ROC also. So we have experience in APMs; we have experience in fee schedule work and with that, five minutes, please. Mai, you're up. Some will have slides, some will won't. We'll figure out how to do that. Thank you.

DR. PHAM: Oh, there you go. So I actually scribbled madly during the last panel, but I'm going to contain my opening comments to this little corner right here and just hope that Bob asks me questions to trigger the rest. I'll start out by saying, you've heard a lot about the distortions and relative prices within the fee schedule and I want to -- I suspect that these folks will give you a great deal of color, but I'll share it from pair perspective trying to build credible value-based payment approaches what the fee schedule means to us.

There are five -- four -- one, two, three, four, five negatives and one positive. So, the first negative is, of course, that these prices are distorted. One of the downstream implications of that is that if you're trying to engage a provider organization in smartly relocating their resources to do more of the things that patients need and that you want them to do and less of something else. They're very constrained and how they can reallocate those resources. And why is that? Because they have to compete for labor in an open labor market and they cannot reduce the price of a neurosurgeon by more than so much, or maybe not even at all and still compete for that labor. So, there's some very real world market constraints. It's not just a theoretical, philosophical debate about which methodology is better.

The consequence of the price distortions is that it distorts the labor market and limits what you can do to reallocate resources. And it focuses, frankly -- keeps our attention focused, I would say on the allusion that we are measuring true input costs with a very, very false sense of precision and from my perspective, a tremendous waste of time and energy chasing that false precision to reassure

ourselves that we're doing something meaningful instead of allowing us to shift our attention, frankly, to what we can afford. I realize that seems overly simplistic, but he said five minutes and I'm trying to keep to this little corner of my sheet. But I'll leave it there. If you could just walk away with price distortion, reallocation of resources, constrained labor markets and this attention to a false sense of precision. The one positive, I will say, and this is where I completely agree with those on the first panel who said that we're going to have fee for service with us for a long time. And that's because I'd like to draw a distinction. I think we need to draw a distinction between fee for service and the resource base relative values go.

Those things historically were married together. There isn't some technical reason why they must be married together. They are separable. Fee for service is a means for paying for productivity and I think we want to continue to find a way to ensure productivity. We don't want long wait lines. If all physicians are getting paid on salary and they have no incentive to see patients as efficiently as possible in a time basis. I like productivity incentives. It's a question of getting the right balance between incentives for productivity versus incentives for outcomes. And so that's why I -- that is a positive from my perspective of having a fee schedule. It's -- just if we could find a way to move away from the false precision and to remove some of the distortions.

MR. BERENSON: Simeon.

DR. SCHWARTZ: Thank you. It's a pleasure to be here. I want to reassure Paul in my opening comments that the establishment of the RBRVS has been extremely successful. It has managed to move almost all primary care physicians to large institutions, as opposed to private practice which is now dead. (Laughter) And the reason -- I have a reputation of being a disruptor. The reason that private practice is dead is that Medicare payments for private -- for primary care physicians have not kept up with inflation; new physicians are coming out with major debt; they're shunning primary care because you'd have to be nuts to take a job that pays half the price of what your education costs; the (inaudible) differential means that you can't possible practice in your own office when the hospital's getting twice the amount for the same procedure.

You have to fill out these ridiculous, inappropriate documentation standards, so you get notes from plastic surgeons that the pupils of equal round react alike and accommodate and the

movement to ACOs and MACRA which I support wholeheartedly has made it for certain that you don't have a future running your own office in primary care. So, maybe that's a bad outcome for a lot of people, but maybe there's some positives of that outcome and I'd like to point out some of them having lived in a world, now, both in the U.S. as well as in the U.K., understanding a little bit about the advantages of physician aggregation.

The first thing it allows you to do is to move money around. You don't have to follow the strict market rules and you now pay market salaries for your physicians to be able to compete for them. You get local control. You get a lot of local decision-making and a lot of decisions as to what constitutes quality. You're able to implement big data and analytics and you certainly have seen this both domestically as well as in the U.K., the enormous value of not telling doctors what to do, but showing them what they're doing as a major driver for not only change, but for financial incentives.

RBRBS probably is a methodologies inappropriate for primary care, but is certainly here to stay especially care as a measure of productivity and also, for its use within large health systems for trying to compare peers. So, maybe the difference between ophthalmologist code and a urologist code is not so valuable, but just think about if you employ 20 urologists, it's pretty helpful to see look to see what the 20 urologists are doing as a basis to begin to consider that. The other thing also is when we put into performance based risk adjustment to capitation, they're able to really now greatly improve the value of capitation. Many people point to the fact that with the capitated models and we look at RAF scores and the gaming that is taking place -- I'm sorry, the creative -- I'm sorry. I was wrong, the accurate coding that is taking place (Laughter). In order to improve RAF, et cetera, but this is a very simplistic understanding of risk adjustment and far more sophisticated models are better.

But I would end my comments by saying that we should underestimate the dangers, the market power that the consolidation has created. We may have a national fee schedule for Medicare, but in different markets, that number could be two, three or four times higher for private -- for large health systems that have created major distortions in market power. And whatever system we do to reform us, we have to really think about whether we want a national fee schedule; whether we want some other basis for figuring out capitation, but we need to basically deal with market power at the level of the playing field. Not only from Medicare and Medicaid, but for all payers and I'll end with those comments.

MR. BERENSON: I'm not sure how I follow that, particularly in the face of PTSD. (Laughter) So, having served 12 years in the army and been in places like Somalia and Afghanistan, the Onvar Profits, I did fine. (Laughter) And then 15 years on the RUCK and I'm a ruin. (Laughter) And I go through that last panel, it's like, "Oh, my gosh, it's coming back." (Laughter) So really, the way we look at this from within the College of Surgeons is that this fee schedule, it served its purpose. As a resource base form of payment, it did what it supposed to do, but it drove volume and it's certainly not the way we practice today. The practice has changed dramatically since its inception to today. Things were must more simple. They were easy to do. They were nice and clean and they weren't -- we just had nowhere the complexity in care. And the care models have changed. It's now team-based care. Nobody takes care of a patient alone today. They're far too complicated. There are too many things we can do for too many chronic diseases, so when a patient arrives into an operating room area, there's a lot more complexity of care than ever existed before. So, when we look at what's in the RBRBS, we're trying to bend around team-based care into these silos and nobody else would ever do this. This is almost insane.

We also see that the specialties pit against each other. I've heard one of the terms I haven't heard in a long time, it was part of the PTSD trigger. I'm non-cognitive. I had no idea. Oh, my gosh, I thought we thought as surgeons, but we don't. We're just proceduralists. That's attention out there. That's not how we practice when we're with patients together. We're trying to solve teams as teams. Really complex issues for an aging advanced population that's unbelievably surviving with a whole new complexity of diseases.

So, when I look at this thing called the RBRBS, it's dividing the field. So, we look at that and said, "This isn't the way to go." And we first started looking at alternative payment models as a way to get out of the SGR and then along came MACRA and it moved us out of the SGR and we said, "Well, now, what are we going to do?" And someone said, "There's this thing about APMs and so, we moved into saying we ought to be looking at how do we build a payment system that incrementally moves us from where we are into population based health. How do we get there? What are those increments? So, we thought about all clear today as we see it is episode-based teams and we can take and have taken about 85 percent of the entire Part A, Part B expenditure and defined 1,200 episodes. Within those 1,200 episodes, we brought 50 to the PTAC to look and consider and said, "Here's the starter set," to figure out

how would we implement an episode-based payment system which actually puts the patient first in that episode of care; measures the quality on the patient, not on the individual team members, but on the patient. And we, as a team, take a count for that quality and we as a team take a count for that cost. So, if the patient does well and the costs are low, the team shares the reward, but if the patient does poorly and the costs are high, the team shares the penalty. And how do we build that and construct that so that it could be small individual practices who join the team as well as fully integrated services who want to take on team-based care?

Well, that's how we're practicing today. We didn't want to make though, so prescriptive that we said, here's the one formula for the way to do things. So, we developed an alternative payment model that actually uses the fee schedule as its chassis that allows us to move from what's in MEPS as fee for service into a MPS APM into a full advanced APM and when you fully feel comfortable taking care of a patient as a team, you could literally go at risk in population based health, if you're ready to make all those jumps.

That's probably a multi-year transition. It's not going to happen in five years. But that was our basis of moving forward. Take the current environment we have, but stop dividing it. Start building the team and move the team into a construct the way we actually like to practice and work together and take care of patients. And figure out that attribution for shared accountability, for taking care of patients the way patients think we take care of them and the way we actually do and stop all this tension and back and for over how do we actually get after all these RVUs.

So, I would rather take resources that are being used to sustain that fee schedule and do the minimum amount to sustain it and maintain it. And take some of that intellectual capital and start putting it into team-based APMs as we move forward. And that's the model we (inaudible). We've built an episode based measure framework and I'll conclude by telling you that framework, the way we put that together, its primary focus is to measure high value process measures that we think ought to be done and are crucial to that episode of care, that ought to always happen.

Just like when you get on the airplane, those pilots go through that checklist, even if it's topped out, I want to know those pilots did that checklist every single time. What are those high value episode processes that need to be done every time. And then I want patient reported outcomes tied to

those episodes so I know actually how the patient felt about what happened. It's nice to have other risk adjusted scientific outcomes that are out there. That's great too, but those tend to be tortured by small numbers. Really looking at the patient reported outcomes, that's what really matters. So putting that episode based measure framework on a construct that incrementally leads us into team-based care that'll transition the population care, that's the APM we built. There's a lot of work to do and we would like to put the resources there. Thank you.

DR. TERRELL: It always sort of frightens me when I agree with everything Frank says, but it's because he was starting the conversation talking about team-based care. It's also interesting though that he identified or was identified as a proceduralist. I'm a general internist and if you will pay attention to the way physicians are named and called, you know how they're paid. If you think about an internist -- when I was in training in the mid-1980s at Duke and at Wake Forest, I was called an internist. And then, we ended up with a managed care copayment system and I became a primary care physician and they lumped us all together with pediatricians and family physicians, even though the actual training and the discipline is somewhat different.

My specialty then changed again, so there were hospitalists, that was about the DRG system. And then there were extensivists which was response to some of the Medicare Advantage type of things. There's now SNIFUS out there, those are in skilled nursing homes. I've heard the term chronisus recently and I guess maybe I'm a cognitivist since I'm still an internist. But all of those are an attempt to define work around a way that you're paid. Just like a proceduralist, all of these could potentially be pejorative if you're not really listening carefully and it has to do with a physician who's taking care of patients; whose function is being thought through within the context of the way they're paid. So, therefore, that sort of defines what they do and a lot of our conversation this morning is about how do we get around that because it doesn't seem to be working.

Well, I think the way to get around that and wherever my slide is -- am I supposed to push a button. I've got one, so I don't have to stand up --

MR. BERENSON: Let me see what I can do here.

DR. TERRELL: I think the way to get around that is to actually go to where we should have started the conversation this morning to begin with. And that is not with the physicians, not with the

physician's fee schedule, but with patients. And one of the things that I believe is true is that if we start with patients and what might be the best model of care for patients and start with the delivery models and the care models and then come around to the payment models that are associated with help, we might get the best outcomes. That's the conversation we ought to have and if we can have those conversations, then maybe we won't have so much post-traumatic distress disorder.

So, I am -- I don't think that advanced alternative payment models are the solution for everything. The slide I have I want to turn into like an animated rubric's cube and so the first to mention would be the population that we have. And it goes everywhere from those that are healthy; those that have risk for disease; those with chronic disease; those with late stage complex disease; those with acute needs irrespective of what category they may be in to begin with if you end up with trauma or acute appendicitis. And those at end of life and that's the concept of population health and we've been trying to figure out how to pay for the populations. That particular payer or a particular provider or a particular health system is taking care of and it's not all the same for every single one of them.

The second component are the types of conditions people have. And so you can have an independent condition. You can have an upper respiratory tract infection. You can have something that is completely and always managed in the outpatient arena. Or you can have something like cancer, or you can have something like multiple sclerosis, or you can have something like the need for a knee replacement and every one of those conditions is defined by part of the population you're in, in what you might need in that context.

So, somebody with multiple sclerosis has a very, very different set of needs and a very different type of care model that might ought to be designed around that then somebody with some other condition, such as an acute myocardial infarction. The third dimension of my rubric's cube is episodes and this is where Dr. Opelka and I have had a lot of conversation. But where do you -- where's the right place for an episode of care to occur? It is not always the case that we need advance alternative payment models for everything. If you're in urgent care and you're relatively healthy and you have an independent condition, then the most efficient thing that you can have is fee for service that is based on evidence based quality parameters of some sort because it's a transactional interaction. You go in, you get something. You come out, or there's some other thing that is a simple transaction. That's a very

different set of parameters than what you might need for somebody who has cancer; somebody who's a geriatric patient, who's frail at the end of the life; and all the types of things you would need for that care model or difference. So, the fourth dimension, if we're going to spin the rubric's cube out of the wall, would be the variation in between the two different groups.

So, the genomics that I'm very interested in, in certain populations because I think it's a hidden factor; the social determinants of health. All these things are not measured within that three-dimensional structure and if we get the analytics right with what we have now, then we've got the fourth data point, if you will, that's going to allow us to design models of care that might actually meet the needs of patients. And within that context, we can come up with a range of possibilities that will actually meet the population we're taking care of.

My final comment is irrespective of what we do, there's always a cheat. I wrote an article about 10 years ago called, "figure out the Cheat," and it was basically saying a fee for service, of course, the cheat is volume. You do things that aren't necessarily -- in value-based care, the cheat is you lie about data points and quality, so you get into false claims act more than you do some of the stark laws perhaps. But there's a cheat in everything because there's moral hazard every time there's a system in place and there's payments in place. If we figure out what those parameters are ahead of time and then we design around them in ways that we can actually focus on patients' needs, I believe what you're going to find out that the medical profession is that most of us on most days are trying to do the right thing. And if you push it back on what we would like to do that's the best for patients, most of us are going to get there most of the time.

What we've seen on PTAC over the last year since we've been getting models are passionate physicians who are mostly coming in with new ways they would like to provide care. And then, they're trying to figure out a payment model on top of it. Dr. Opelka was the exception of that. There was a lot of thought with respect to the payment model. But we're seeing people from all over the medical spectrum saying, "If I could just be paid differently, I would this for patients or I would do this for patients, or I would do this for patients. And the models are awesome and they're from all different types of patients.

So, let's think about the patients first and design models around it for the payment and

there's not going to be one solution. It's going to be a complex world from now on.

DR. LAZAROFF: Thank you. I'm really pleased to be part of this August event with these distinguished panelists and when I saw the agenda, I worried that by the time I got to say anything, everything would have already been said. And I think that's -- now, they put me last on this panel, so I have a certain disadvantage, but it'll help me to keep my remarks relatively brief. But I won't entirely be able to avoid repeating some things that others have said and the first is that the RBRBS is not going be easy to kill. That even if you have a capitated organization, you still have to have some way to get the money down the individual provider because, you know, they're not -- unless they're all employees, you could do a salary I suppose, if they were all employees, but I don't think we're driving toward that kind of healthcare system.

You can use capitation to get the money down. It better be risk adjusted, but in the case of capitation, you have to decide who do pay the capitation to. And I would argue that the current mechanisms of attributing to a primary care doctors and so on by the number of visits and all that is not adequate and you've got to have a more explicit definition of who is the person who's supposed to take the responsibility and receive the capitation payment if we're going to go in that route.

I'm hopeful that the patient relationship codes that I had the opportunity to work on contribute to -- will help us with that to define the roles of different kinds of physicians so that we can use that information to figure out how to pay in these kinds of situation. I want to say something about resource based relative value scale because I find that with the except of the people on these panels and probably some of the people in the audience, most people have not thought about what is the implication of resource based and why was it setup this way. And was mentioned earlier, this was supposed to emulate a market because the theory is in a market, market forces will drive the payment down until it gets to the point where it equals the cost of producing a service plus a reasonable amount of profit.

And that was the theory behind it. But the problem is that getting those prices in an administered pricing system is very difficult. And it's been alleged that the fee for service system is inherently inflationary and I would like to say that I think that the reality of more nuanced. It's inflationary when the price is too high relative to the cost of producing the service, but equally important is that it prevents things from being done when the payment is too low or the payment is zero. And as one of the

questioners mentioned and that equally pernicious in my view to the fact when the price is too high.

What's happened for fee for service -- for primary care physicians, is that the price is determining the service that is provided, whereas, what's supposed to happen is the medical need for the service is supposed to determine the price. But it's been flipped and the result is that only the things that you have to do are getting done and the real definition of the E&M codes is the documentation requirements which have almost nothing to do with the practice of medicine. And essentially, as long as you meet those documentation requirements, you'll pass an audit, but you may have done nothing for the patient and that's a bad effect of a fee for service or relative value scale type of reimbursement.

That is not necessarily a feature of a capitated environment or even a salaried environment. Bob gave us some questions to answer and -- or to think about. And of them is, is it worthwhile to have developed and be working on these new codes for transitional management, for chronic care management and so on and so forth. I'm totally biased because I did a great deal of work with CMS and AGS and others to develop those codes. I think codes are consistent with the direction of healthcare reform. Helps physicians build the capacity that they need to participate in alternative payment models. Makes the underpayment for cognitive work less -- especially if we're caring for sick patients, less severe and, you know, my observation is even if you have a globally capitated organization, they're going to start off by paying the individuals by referring to the RBRBS. And if Frank's surgeons get paid upfront for doing work, I want to get the same benefit of getting money for doing the work upfront. This is, you know, in the RBRBS, this is a resource based thing and if I'm putting the resources in, I should be paid for that. I think that may be a transitional stance, but nevertheless, I think it's important.

How does the fee schedule affect the ACO? In my experience with the pioneering ACO and the MSSP physician health partners in Denver. Just a little background, this is a primary care physician-owned management services company with an IPA structure linking the physicians together, about 200 PCPs. We did global risk Medicare Advantage very successfully for -- and still do. We've been going for over 20 years and 30,000 in MMSP -- 30,000 members, but over 300,000 overall in commercial and Medicaid, all variety of issues.

So, what's our biggest challenge for that ACO? The biggest challenge is recruiting primary care doctors. Why is this? Because there's a shortage of primary care doctors, especially

general internists where you really want for Medicare patients and we have Kaiser. It's very influential in our -- it's a good organization. Hospital systems trying to build integrated delivery systems. They need primary care doctors to do this and they will pay what the market requires in order to hire those people, but our private physicians that are out in the community who are relying on the fee schedule to generate their revenue, they cannot compete with the hospitals and with Kaiser and so on financially.

Also, there's NIPs and all these other reasons, so as others have said, everything is being driven into these organizations. That's the real problem that we face with the fee schedule is that the market demands a higher paying for the primary care doctors than the fee schedule can generate.

Just two more comments. I want to respond to what Dr. Opelka said and after listening to Frank speak, I will admit that surgeons do think (laughter) -- I'm quite sure of that, but I would argue that Frank has skills to do his surgery that I do not. And because of that, in the fee schedule, there's an intensity adjustment to account for that difference. But I would also argue that I have skills that Frank does not, but the assumption and what I think is maybe the original sin of the fee schedule is that all physicians of every specialty are assumed to have the same cognitive work skills and I dispute that. I can't do his work. He can't do my work, but this has created an imbalance in the payment because only procedural work is recognized as requiring special talent, training, skills and I think that's not true. And with that, I will stop.

MR. BERENSON: All right, so I think we've heard some different opinions on some topics and I want to push that a little more and ask a couple of my questions to the panel and then we're going to open it up to the audience to sort of take -- I think I've got this right. Frank was pretty strong about arguing one, that the coding can't keep up with the practice and it probably can't given the nature of team based care, et cetera. It's hard to capture that encoding even if one tried to continue to update the coding. And made a pretty strong case around opportunity that it's difficult enough to get everybody's involvement with working on APMs to then have this huge distraction of arguing over AVUs within the fee schedule. If I've mischaracterized your position, you can clarify it.

Alan, I think, said fee schedules are not inevitably a problem. It depends on the prices that you set and that it is at least potentially, if possible, to get more value out of a fee schedule by getting

those prices closer to what will produce better mix of services and outcomes. I'd like to go and hear from everybody where they come down on this issue of do we want to sort of sunset the fee schedule; let it do as Frank said, do the maintenance, you know, minimal maintenance and really move decisively to APMs, but that is the question of which APMs, but you could take that on, or is it worth major investment in trying to get the fee schedule better if we could get a consensus on what better means. So, Mai, why don't you start and then pick it up from there.

DR. PHAM: I think I'm somewhere in the muddy middle. I think I am pragmatic enough to - for both practical reasons and because I do believe that there are certain situations where fee for service is simply the best, most appropriate way to pay. I don't know why I should pay for cataract surgery any other way then fee for service, as an example. But I'm very skittish about the concept of a major investment to address the pricing distortions. I think that we could think about going for the lowest hanging fruit and stratifying the distortions in terms of their magnitude and their impact in the marketplace and address the highest impact codes and then see where we are because frankly, I agree with Frank that there are lots of things that a fee schedule will not be able to do for us and that the nature of care delivery is going to keep moving in that direction of not having possible bits that you could link direct fees to. But I think that, to be honest, to actually price those things and make those things go in the marketplace and sell them as a concept to providers on the receiving end, I have to have the resources to do that.

Whether I'm at Medicare or at Anthem, I can't invent dollars that aren't there. I can't keep investing more dollars in primary care without taking it from someplace. What customer would I sell that to? And so I do think we need to work this with both hands and short of a major investment, I think that it should be doable to address some of the highest yield portions in terms of price distortions and then see where we are. It gives us a little more breathing room to start moving, you know, to start adding those layers of alternative payment models as a complement to, not necessarily as a replacement for fee for service.

DR. OPELKA: I would not invest a lot of money in fixing the RBRBS schedule. I think I'd let it die its natural death as we move to APM models over a period of five or ten years, but I would offer primary care physicians an alternative capitated model as quickly as possible that allows them to have a

different payment system. It could be voluntary for primary care physicians and quite frankly, it could be voluntary for patients. But what would happen rapidly, is that the physicians that signed up for this would only see patients who signed up with them as primary care physicians. It would not really distort the entire system. And when I was going to price that, I would do it the opposite way we've done everything else before.

I would figure out what the market price for a primary care physician; I would understand when the appropriate panel size for those people are; and I'd understand that the bucket of services that they need to provide to those patients with a lot of emphasis on the coordination of care that was, of course, risk adjusted.

DR. SCHWARTZ: So this is to me -- I think we're -- this panel is more alike than it's not. And the way I think about this is I really try to step outside the fee schedule and ask, what is it that the patients need in the emerging market and what are those market forces that are out there? And then, how do I adjust what I need to within that fee schedule. Stop going back to the old fee schedule think and all those RVUs and tell me more about the story that Alan was making that they're skill sets that aren't appreciated in primary care in this current construct.

Well, forget the current construct. Where's the construct going that I need to go and how do I appreciate primary care the way I need to. And it's no different in surgical care either. We talk about so much of the primary care can't afford the way they are. They've moved into being employed. We just finished a survey of the surgical community and I can't tell you what the final number is because we're still looking at the results, but over 70 percent of surgeons are employed and the number's growing at a very rapid rate. It's doubled in the last decade. And it isn't because they can't afford the RBRBS that's out there. It's that the complexity of practice is such that they're not getting to operate. They're managing rules, regulations and EHRs and ONC and all this other stuff and they want to get back to patients and that's all they want to do.

So, they can dish that off on an employer and get back to patient care, fine. That's where they are. They're also not being paid purely on the RBRBS. It is a marker. It is a tool that's needed to determine their value within the system, but there's also directorships and other administrative responsibilities and other ways that physicians are being compensated. It's become much more complex,

so to me, let's put that effort into -- let's describe where this is going and figure out how we're going to value it. The current system we have, the RBRBS is a base system, but there are flaws in it that don't meet where we're going. Let's put our effort in fixing the valuation in those flaws that meet whatever those services are that patients need as care models change.

DR. TERRELL: Mai started her comments talking about that she saw no other way of paying for cataracts except possibly fee for service, but fortunately, there's only two eyes, so there's going to be a limited amount. And I'm only partly facetious. In pure fee for service, if you don't -- if you have no way holding people accountable for appropriateness and quality and outcome, then you may well not still have something that you want, even though, in my opinion, parts of the system that could probably do pretty well with what would be considered traditional fee for service, but there has to be some sort of performance or quality on top of it.

And that's where you get into all the complexity that Frank alluded to that has gotten awfully, awfully complex. So, I have over the course of my years in practice, practiced in a three-person practice. Practice is part of a multispecialty group what I helped founded. In '95, it started with 42 docs and ended up with 375 before we merged into now, part of a large integrated academic lead medical system in North Carolina and a lot of those moves were always related to market forces and some of those market forces now are just the expense and the complexity of the management. And part of it is just market power.

An organization like Cornerstone who had some of the best performance in the country with respect to the quality and costs that we were delivering as an independent multispecialty group could not survive independently when hospitals could pay rates to some of the higher earning specialists that were $2 to $300,000 more a piece and we thought we were paying market, but it was that hospital differential. So, within the context of what all that means for fees and services and how we ought to pay, if there is going to be continued consolidation in the systems, it will solve part of because there'll just be big systems that'll be getting the money, I suppose. But if the level of what needs to happen for the patients if we do not have something underneath that's holding everybody accountable for the costs and the quality and the outcomes in this complex world that we've developed, then we won't get what we ultimately need out of any of the stuff that we've wrought over the 20 years.

DR. LAZAROFF: I think I agree with the other panelists too -- I think the differences among us are not that great, really.

DR. TERRELL: Yeah.

DR. LAZAROFF: We mostly are all thinking about the same things. I would point out as a geriatrician that fee for service has not been kind to geriatricians. That's for sure and that's why, as Bob mentioned in the introductions, you know, I did PACE many years ago. I was very involved in that and then have been involved in Medicare Advantage and the ACOs and so on and so forth, so, I don't -- wouldn't portray myself as a big advocate for a fee for service. It's just that I don't see how the heck you get rid of it. It's not going to be easy to get rid of it.

I just -- one other comment I wanted to make is, you know, a fee for service system, if you can rush, as a primary care doctor, if you can rush through four or five sick patients in an hour, that's not efficiency. That's simply not doing the care and that's a basic problem that we have with the way fee for service is structured. The other point is, you know, primary care is really in trouble and we need some relief right away because if it takes another 10 years to get to alternative payment models, there won't be any primary care doctors left unless something is done in the interim. And so, you know, although we've -- it's now -- I think it's in the seventh year since (inaudible) ACO came out. We still don't know if this is going to work really and where we're going and so I fear that, you know, part of what we're saying is anything has to be better than what we have right now and if you look at the Graham-Cassidy Bill you know that, that logic is very strong. So, we've got to have something to replace fee for service that we're confident will work. And I don't believe we're there yet. We should move in that direction, but I think we still and I just would say, I think we can chew gum and walk at the same time and work on both ways at the same time is my opinion.

MR. BERENSON: So, let me ask one more question and then we're going to open it up to the audience to maybe make it a little more difficult, the answer to the first question. In the notes is a proposed rulemaking CMS to their great credit identified the documentation guidelines as something that may have -- let's just say -- I'm trying to come up with the right term. No longer deserve to be given the same standing to distort medical practice, the medical record, the electronic health records, all of that stuff is a -- my first job at CMS actually, when I showed up in 1998 was to do the fly in at the AMA and

defend the new documentation guidelines that had been promulgated, I was the messenger. Twenty years later, I think they have not served their purpose and are counterproductive and so CMS was asking for comments about it.

In providing comments, I sort of -- well, one of the points that I'm making here is that in their sort of discussion of the documentation guidelines and if any of you don't know what that's about, ask a neighbor or something like that. We don't have a chance to get into it in great detail, but they pointed out that there -- their observation was that when they were written and asked for particular items of histories and physicals that had to be documented in order to justify the coding, the five levels of coding, medicine -- the practice has changed so that, that's not necessary. And the focus should be on decision-making, which is the third component of most of those CPT codes.

So in preparing my comments for CMS, I actually looked at the following, that there are 6,500 separate codes for procedures. Every nuanced variation of a procedure has its own CPT code. There are essentially 16 codes to capture all of the cognitive work that all physicians are doing and Alan pointed to the fact that there's cognitive work and there's cognitive work and specialists do different things. There are physicians that do spend an hour doing a history and physical.

Neurologists, dermatologists do histories and physicals, but they're not the same thing as a neurologist's history and physical, so I'm sort of raising the question of if we really wanted to sort of make progress, this is a hypothesis, we would begin to provide the nuance in E&M coding that we have in procedures. But as Mark Miller suggested in the first panel is that taking us in the completely wrong direction by making the fee schedule even more granular and creating lots more codes and having everybody's perfect description of what they do as a code, or not.

So, I guess my question to the panel would be, is it worth the effort to sort of find out what physicians actually do and try to redesign the coding system to capture what they actually do and then try to keep up with that, or is that a bridge too far. We should really not go down that route and we should really focus on alternative payment models. That was a long preamble to that question. Mai, you want to -- your leap forward.

DR. PHAM: Yeah, I'm always first -- (inaudible). (Laughter) So I think it makes me look like I blessed her more because everybody else gets to sound thoughtful and reactioned. (Laughter) I'll

just -- I think this is one of the are instances of me straying from Bob Berenson's world view. I really do not want to generate new codes. I really, really don't want to generate new codes. I'd rather find a way to grossly bring that number of 6,500 procedure codes down to something like a hundred procedural families and pay for those. And I would rather not require documentation at all. I think it's fine to stick with the 16 E&M levels, whatever, whatever, but not require documentation at all. If, for example, you at downside financial risk. What do I care? It's your dollars, right. If you're taking that accountability, I would really, really rather not move in that direction.

I think for purposes of research and analysis, it may be interesting for a time, but in my head, what I'm thinking about are all of the jazzy new tools and services being brought in Silicon Valley and other places around the country, wondering about when artificial intelligence will really start to creep up in medical care, I'm wondering about how rapidly, as Frank says, our care models are going to change right under our feet. And to try to -- and to imagine that we can scientifically keep up with that in real-time and reflect those in hard wire documentation requirements or specific fees, I think is a fool's errand.

It feels a bit arrogant to think that we could do that. The same flavor that I have -- the same sensation I have thinking about the false precision in today's RBRBS. Let's not project that we think we know these things to such an exact level. Let's just, you know, shoulder some humility and say, "We're going to try to get it roughly right -- roughly directionally right and we want to, you know, if complexity is what is driving independent practices into the arms of larger institutions, let's remove some of that complexity and let's just accept that we're willing to live with a certain level imprecision in order to get closer to goal in a whole host of other ways."

DR. SCHWARTZ: Very thoughtful comment. No, for on the spot it's pretty good. (Laughter) What happens if the alternative payment models don't work? (Laughter) I'm actually, you know, dealing with that issue every day now in the U.K. So, one of the things I also spent a lot of time looking at big data and looking at high level analytics and I'm really amazed at how much you can tell about people.

What's it worth to pay an internist who does four hypertension visit follow-ups a year compared to his colleague who does one and manages the same patient with hypertension? So, you'd think for example, that the APMs take care of that because organizations will figure that out, but actually,

we can figure that out too on a national basis. And one of the alternatives is we really understand risk and understand who the patients are; understands how much medicines they're on; get more and more EMR data on each individual patients. We know who the patients and we already know what you're doing. And one alternative that the APMs do not work is to go to a single primary are code -- visit code and retrospectively do analytics to determine the acuity and the intensity of the visits and adjust physicians' incomes accordingly as bonus payments at the end of the year or whatever to reflect who they are; what they've done; and how they've managed it. That's doable today analytically. We may not want to do that. It may not be politically acceptable, but most importantly, if APMs fail, which is my preferred model, we may need some alternative mechanism for primary care.

DR. SCHWARTZ: Right. So, I'm listening to these two comments and particularly to what Mai was saying. She wants a hundred code areas to deal with. Well, we put 1,200 together which we have actually started doing vision compressing into other groups that we call clinical affinity groups. So, a cancer group, muscular skeletal group, a cardiac group and those would be -- would have sub-episodes within them, but could roll up into a population based health payment system. And that, to me, is much more worth the effort and at the same time, Dr. Schwartz is talking about how do we apply real business analytics; how do we start to get into using digital health information in a way that starts to reveal optimal points of care; how do we actually move from where we currently are into artificial intelligence and deep learning, or we could spend our time writing a whole bunch of new codes to chase in a fee schedule.

I would rather be linking this closer and closer to the clinical environment in which we live. Now, Bobby also retriggered more of my PTSD (Laughter). You see, I was on the original Documentation Guidelines Committee (Laughter), so -- and I looked at that and back then when we did that, it made sense. In the digital health environment we have today, it makes no sense whatsoever. And so I look at all of that and say, "Let us modernize that documentation again, to meet the care models." How is this team communicating to take care of this patient, rather than how am I counting the widgets so that I can code a bill right? We've got the emphasis at the wrong point and we're missing the real opportunity to better care. So, I would redesign that documentation so that it's flowing and tracking with the patient and that information is where it needs to be when it needs to be there for the clinical decision-making, not for

accounting systems that get payment done. We're missing the point if that's where we are.

DR. TERRELL: So I was practicing medicine this week, this past weekend on Friday, Saturday and Sunday seeing patients and I saw my usual geriatric population in chronic care on Friday. And there was a -- one of our nurse practitioner's father had died, so I was doing the convenience care and I saw -- I don't know, I think we saw about 50 over the weekend in team based care. And a lot -- there's a virus in High Point, North Carolina, so a lot of people came in with, you know, a viral upper respiratory tract infection and I didn't do anything for them except tell them to go home and I didn't prescribe an antibiotic and it took me a lot of time to document it because most of the EHRs today are billing systems masquerading as medical records.

But one of those patients that I saw, I'm pretty sure she actually was (inaudible) mycobacterium avium complex and you probably can't tell it from my record other than that I found a CT scan that somebody has missed and put two or three extra sentences of documentation. The complexity, Bob, of actually having to go through and explain why I thought that patient was different than everybody else and what triggered my thought process and why I did what I did, it's just a nuisance in the current system.

What needs to happen is there needs to be enough that we get it done so that we -- so that the patients get what they need, but I think that if we basically start with the billing system, the documentation will occur because the IT always follows the money. So the reason the IT is so terrible now is because it's about the fee for service system and documenting -- and the documentation so that we can get every little point. And the next little thing that's happening now are the RAD scores and the ACCs because that’s the new way of getting money from Medicare and some of the alternative payment models.

So, let's design the system and the IT will follow, I believe, but we got to get the system right first. The money will follow -- I mean the IT will follow the money.

DR. LAZAROFF: I think it's possible that 6,500 codes for procedures is too many, as a matter of fact, I'm certain of it, but I also think at the same time it's possible that 16 codes for primary care is not enough. There was an effort made in 2000 -- around 2005 to raise the value of E&M codes to address the problem that we've all talked about here today, but the problem is that every physician of

every stripe uses E&M codes and so the budgetary implications of changing the value of the E&M codes is just humongous and it is the cornerstone of the entire payment system and if you were to raise that by 50 percent, it has huge implications for every other kind of physician who, for some reason or, you know, are not thrilled with the idea of their payment going down because of budget neutrality.

So that's the reason for developing these other codes, like the transitional care management code and so on to look for work that the dermatologist does not do. To say that not everybody does exactly the same thing in E&M. Is that an ideal solution? No, I don't think so and it's going to be limited. It can't fix the problem, but at least it starts to recognize some of this work.

The other issue is, you know, I sit on the RUCK and I want to tell you that the RUCK values these codes to the hundredth of an RVU. This is absurd. The data, it can't justify that. It's not humanly possible to maintain a fee schedule where you put 7,000 in exactly the right relative position. And so I certainly agree that we need fewer codes overall. I'm not -- I still -- maybe it's because I worked on them, but I think that there is an opportunity in primary care type of services to recognized that hasn't been adequately recognized previously. And at least there's an interim assist that I still think that's worth doing.

MR. BERENSON: So, now that we've achieved that consensus, let's open up the floor for questions from the audience. We've got Paul here and then we'll go to Jim.

DR. GINSBERG: Thanks --

MR. BERENSON: Paul, by the way, if you haven't been introduced earlier, please tell us who you are and where you work. We know Paul.

DR. GINSBERG: Sure. If you can't see me, I'm Paul Ginsberg. I've been listening to this panel and the word investments was used many times about, "Well, you know, maybe some investment is okay, but not a lot." And I want to sort of ask the panel to clarify what they mean by investments because I don't think they're talking about large numbers of dollars, at least in relation to what we pay for health services. I think maybe by investment, they're talking about getting policymakers to do heavy lifts on something and there are alternatives to where we can push them and when we talk about alternative payment, maybe the biggest investment we need there is to get policymakers to coax patients or consumers to commit themselves to delivery systems so that it would be a lot easier to do

these approaches. And maybe that's one of the restrictions, the lack of investments in pushing the consumers around.

DR. PHAM: Yes, there are some real-world constraints. And what I meant when I said investments was I think what you meant, which is it's an unbelievable amount of time which comes with opportunity costs and people resources. Chris Ritter is sitting right behind you and she's probably going to die sooner because of all the work she's put into the fee schedule. It's also political capital, which itself, comes with opportunity costs. And sitting from the payor's seat where we are actively considering maybe we should define rebalancing of the fee schedule as a part of alternative payment models. Not something separate from it. All of those things come with cost. That's what I meant by investment. Wholeheartedly agree with you about the desirability of having patients be more sticky, but I think that's it's important to ask the question upon what basis. Is that stickiness just to help the provider do their work better in terms of managing that care? Is it to generate awareness and outreach among patients and consumers about how the healthcare system actually works and the industry actually works? I think we want to think that through pretty carefully because I think that no one has pushed that needle as far as it could go, but in part because we haven't de-conflated those various issues.

SPEAKER: (Inaudible)

DR. OPELKA: Yeah, I agree with what Mai was just saying, but I think it's an interesting point you raise about if we change, we move from fee for service to an alternative payment model with the physician and the delivery system community, but the patients remain at a fee for service model, we haven't done anything. And when I talk to those folks who help us to modeling at Brandeis and I asked them, "Well, how are we doing with the concept of a medical home?" And they said, "Well, the patient community is not in medical homes. When you analyze this EMS data, they are not in medical homes." The doctors maybe think they're in medical homes, but the patients still go where they want, when they want, why they want. So, we have a patient community that's in fee for service. So, if we're going to move this, we've got to move everybody. We've got to move the whole model and we have to communicate in the implementation strategy. We have to communicate and get buy-in by the patients and we don't have that today.

MR. BERENSON: Next question.

DR. SCHWARTZ: Well, I'm sorry. One quick thing.

MR. BERENSON: Oh, go ahead, Simeon.

DR. SCHWARTZ: Another investment emotionally in top-down redesign makes it less likely that we will have innovation and bottom-up new models to pick from in the future. And I think that's very important to create an environment that people are encouraged to innovate and to bring forth new ideas.

MR. BERENSON: Grace, (inaudible)?

DR. TERRELL: Well, I'm not sure I like the idea of patients or consumers not having choice. In the market-based system, if we were able to come up with a way that we actually were providing a better product, choice would be an okay thing. Now, you could have choice -- a system choice level as opposed to a provider choice level, but if you're going to go with that idea, I think it has to be designed with the concept that patient choice ought to be like any other thing. It ought to move with quality and with patient experience and not just be where somebody feels trapped in a system. So --

MR. BERENSON: Tim, over there, a question? Tell us who you are, Tim.

MR. HONARAN: Tim Honaran with the Congressional Research Service and a quick comment and then a question. The comment is that I'm often, and again, CRS works confidentially, but this is general enough that I'm not violating confidentiality. I'm often approached by staff who want to discuss a new proposal or a new bill to create new codes for whether it be telemedicine or positron therapy or whatever and my -- one of my first responses is if you code it, they will bill. You might be happy with that. You might not be happy with that, but if you code it, they will bill based on experience. And also, the second part of that is CBO is likely to (inaudible) is increases in federal budget.

Though, my question has to do with the types of APMs that we're trying to -- starting to see through the QPP versus what I refer to as a complete payment system. The distinction being that the payment system is exhausted. Whereas, what we're seeing with these APMs are oncology carve outs or joint replacement carve outs or chronic care management carve outs, which means by necessity, you have to have something else that wraps around everything else, which in most cases is going to be fee for service in the RBRBS.

So, while I've heard a couple of you talk -- excuse me, talk about -- I had a big bone fly in

my mouth while I was biking to work today and I -- it left after a fight, so I have kind of a swollen throat. So, I've talk -- a few of you talk about these -- developing these payment systems that have a reduced number of codes. But I'd like you to comment on the importance and where we should put our efforts between these carve out models which necessitate the reliance on a backup system like fee for service versus going to an alternative -- completely alternative payment system, which frankly, I think are behind right now.

DR. TERRELL: If I could start on that. I don't agree with you on a couple of things. First of all, with respect to the codes, I probably do agree with you on that. What I'm learning in the genomics world is that there's now 70,000 genetic tests and only 500 CPT codes for all of them. So part of the issue with technology and all of that is that we may never be able to, even if we wanted to have 77,000 codes or whatever for genomic tests be able to keep up with that just because of the complexity and so there may need to be another way.

I don't think -- what I disagree with though is I don't think a fee for service has to be around at what you're calling a carve out. So, if you looked at the slide that I put up earlier, I was saying that there may be areas where bundles are important or areas where you have to have an overall population payment for which a bundle is a component of it, or other areas where fee for service. The complexity in that is not about a wrap around. It's about linking all those into the total cost of care in a community. And so, if you have community based payments for which there's various types of components that are out there, you may well be able to fit all of that in, but you could certainly have a, for example, an advanced alternative model system that was contracting with a oncology medical home to provide certain services within it. It wouldn't have to be fee for service around it in my opinion.

SPEAKER: (Inaudible)

DR. TERRELL: Right, a bundled payment in and of itself would just be a component of the larger healthcare needs of a population.

DR. PHAM: I agree with Grace. I guess the way I would characterize it is what you're calling carve outs, I think of as the first baby steps. You know, in reality, if you talk to most ACOs and you ask them how they're engaging their specialists, you got one of two reactions. It's either a blank stare or sheer terror. There's really nothing in between and they actually rely on payers to step into that void and

to help think about how to entice, engage, cajole those members of their care community to actually engage in this work.

And so, things like episode based payments; or you know a specialist medical home models, they're, I think where they're really useful is to begin that engagement in a very concrete way, but I completely agree with you and with Grace that you need a system around that and that all those pieces need to knit together deliberately. It's not that, you know, if you sprinkle oncology medical homes in the market and a few ACOS layered around there, it's not like the work is done. You actually have to knit those things together so that everyone is playing to the same total cost of care goal. We think it can be entirely possible to do and sometime in quarter one of next year, or late next year, maybe we'll have evidence to show for that, but that's definitely the direction that -- and to be also clear, it doesn't stop with payment.

To Paul's point, if you have a great payment product and you don't have the insurance product design around that to engage the beneficiary, the member; if you don't have the sort of consumer centricity strategies around that; if you don't have the right data around that, all those things make for an accountability system. We've been talking about payment today, but let's not kid ourselves that even if we figure that out, we've solved the problem.

MR. BERENSON: (Inaudible) then Frank.

DR. LAZAROFF: So, first I will say that for primary care doctors, I think the total cost of care is the only rational metric for our population. I'm really -- I mean, I'm troubled by episodes that begin at primary care that are defined by disease because I don't think you can adequately risk adjust those episodes and it's really very, very difficult to do that. If you look at, for example, I would rather have -- be evaluated on what's the cost of care of my entire population, rather than what's my cost of care in taking care of patients with COPD, for example. I think there are technical problems that will be very hard to overcome.

The other point about the episode is, as a primary care doctor, the way I can affect the episode most is by seeing to it that it doesn't happen; that preventing the episode that the person doesn't get hospitalized for congestive heart failure because I did a better job of managing the patient as an outpatient. And most -- the question is, what triggers the episode and most of the episodes that are being

looked at so far are triggered by an operation or by a hospitalization. And I think that completely misses the world of primary care doctors in controlling costs since we most of us no longer are going into the hospital and so on and so forth and we're in the office.

DR. OPELKA: I would take a different approach to this and I think you're raising an important issue if, to me, we come up with 10, 15, 12 different versions of alternative payment models, then that's a lot for the payer to have to manage and implement and it's a lot for the delivery systems to have to manage and implement. And it's adding an additional burden. So, when we put our modeling together, we wanted to create a framework that would allow us to expand and allow and incorporate all sorts of different types of models of care, whatever they are.

An episode, as we describe it, can be triggered by a CPT event. That's how it was designed, so it was triggered by an outpatient engagement, rather than an inpatient event and that episode can be a yearlong. It can be 90-days long, however, you want to design it. And it can take clinical risk adjustment. It's currently claims based risk adjustment because we don't have enough clinical energy currently to allow us to do clinical risk adjustment, but we individually priced the episode for every patient. It's not by this procedure of this condition costs this much money and you have to manage it within that. No, it's by the patient and the other comorbid conditions that patient has that allows us to price that model out and we've done a ton of statistical analysis on this.

The beauty is that to my point, when you do go into the ACO. They don't know how to analyze their patient beyond chronic care and it's only a few diseases they can do, eight or ten diseases in the chronic care environment. Beyond that, they don't have a way. This model allows us to go into the ACO and break it down. We could say, "Okay, here's how you vary from all other ACOs and how you cared for your population risk adjusted." Now, again, it's still grainy. It's not highly focused, but at least it gives the ACO an opportunity to look inside and say, is our variation warranted or unwarranted. Let's start to look and see where we vary, what's going on? Whether we can justify it or not. Currently, they can't do it at all.

So this is actually a great tool to put inside the ACO to break it down into digestible bites of the elephant so that you can look at it and start to say, "Where do I begin to understand variation and whether my variation is warranted or not?"

MR. BERENSON: Well, I'm aware of two more questions. One is right here in the front and then one in the back and then we're going to (inaudible).

MR. ZUCKERMAN: Okay, Steve Zuckerman, the Urban Institute. I'm going to ask a question. I think it's going to go to Frank, but other people can pick up on it. If you create these APMs, whether it's one APM with a lot of different models, or several APMs, presumably, these payments have to go from an insurer, whether it's a private insurer or Medicare to a provider or a provider system. How do you figure out how to price those APMs if you step away from RBRBS?

DR. OPELKA: So, the way we envision the model because it begins -- the chassis is built on RBRBS. So, it begins with RBRBS to sit where it is today and then we envision that over time, if you've taken on enough risk and you've got a huge clinical affinity group, say, cancer or cardiac care, or muscular skeletal care where you know all the sub-episodes and the sub, sub-episodes because there's a lot of concurring episodes that co-running all the time. You can actually analyze and know predictably what your risk is with that population and go ahead and say I can set a population based health risk, PMPM for this population knowing these actuarial risks that I've been running for the last two or three years and you can step out of RBRBS and say I am going go at risk with these providers to provide these services within this clinical affinity group.

SPEAKER: If you start with RBRBS and you can monitor care you -- does that mean over time would be lower prices because (inaudible) managing care?

DR. OPELKA: Yeah, the incentives -- the way the system's designed, it's a race to the bottom, so it measures quality. Quality is broken down into four tiers of excellent, good, acceptable and unacceptable. That's first, cost is second. So, if you're measuring quality over cost and you're being rewarded for shared savings in the model, you're actually driving down the model is intended. You know, we have to prove it over time to actually race to the bottom of the highest quality at the lowest costs.

DR. SCHWARTZ: What I would suggest is that when you begin a system that looks at historical costs by specialty and by procedure, all you're doing is immortalizing the current distortions in the fee schedule system. Right, so that, in fact, if you were to design a new system, and I'm not very detailed understanding of how Kaiser works, but my understanding larger departments have budgets and they manage to deliver the care within those budgets. They understand what the markets costs are. So,

if you don't start with a system that starts with what are your costs today to deliver this care within this budget for this population and then break it down by specialty. At one point in my career, almost 20 some odd years ago, I was a consultant for Westchester for Kaiser and I got $0.54 per member per month for oncology care for their entire 30,000 population. And I thought it was the worse deal I ever negotiated. At the end of the year, I looked at it, it was one of the best deals I ever negotiated and it seems ridiculous that $0.54 was going to make it. But that actuarial was a very good value for what it was. And that's not based on what my historical costs was. That was not based on what my RBRBS was, it was a completely parallel system based on their allocating a budget by the cost of care.

DR. PHAM: So can I answer with respect to the future APMs rather than the current APMs? With respect to the future APMs, yes, you start with that chassis, but then you actually try to address some key distortions within that chassis at the same time that you are -- I'm forgetting my thought here. You're asking about moving people off of that chassis. I'm going to come back to you Steve because I had a really good thought, (Laughter) but I wasn't used to waiting so long before -- (Laughter) --

MR. BERENSON: (Crosstalk) you were going to first. Well, we have one question back there and then if you come up with the answer, we'll turn back to you.

MS. LOCINSON: Hi, Maryann Locinson from Columbia University. I too have PTSD from writing a book about RBRBS, but nevertheless, I was very heartened to hear this concept of simplicity and coding. I'm really interested in hearing about how we consider encourage more innovation and the definition of services. So, stakeholders from physicians to payers.

DR. TERRELL: In the innovation of service, my experience, which I alluded to, but didn't describe when we were at Cornerstone, was to start with care models and say, for this group of patients or that one, or that one, or that one, what would be the best care? So, we designed a set of services around patients that were dual eligible. We designed a COPD care model. We designed a care model with innovative behavioral medicine into a congestive heart failure model. We designed a model around oncology care that looks similar to some of the stuff that's being done now. We did a super duper complex medical home on steroids kind of model for patients that were frail and with that particular population, we embedded pharmacy services and man y other types of services not typically embedded into the model. So, in each of those situations, we were very innovative. We had fantastic cost and

quality results that came out of it, but it was putting together what we thought the patients needed that were the particular patients that we were approaching that we felt were challenging in the way care was being delivered in the traditional way.

I think all over the medical healthcare industry community right now you're seeing a lot of people starting to have innovative ideas partly because of new technologies that are available that are getting things out of facilities and partly because just the, you know, the tantalizing idea maybe that if they can get into an APM they don't have to do MIPS or whatever they get their 5 percent bonus. Even though it's -- it's just the hope of that you're getting a lot of innovation out there from the communication, so I don't think you're going to have worry about innovation. I think it's going to come from people that are thirsty for it, who've been taking care of patients on the ground all the time. If we get our payment models right that can actually be married to the care models that would be more appropriate.

DR. OPELKA: We struggled with trying to improve the patient experience that when you call the doctor's office, we actually answer now 80 percent of our calls within 30 seconds. And that required building a pretty massive -- we have about 250 agents in our call center. The impediment to doing that was what the patient wanted to come in for and we had approximately 300 hundred visit types. We now have in primary care and internal medicine and pediatrics one visit type. It's called visit. It was really hard to get to. It took a lot of complexity to get there and a tremendous amount of political capital. But if you call and you say you want to see the doctor, we give you a visit. And if you go online, you want to book that, you book a visit and it works out.

So, a lot of the complexity that we have created for the purposes of our billing and for our interactions is really irrelevant to what the patient wants and it is not productive for delivering high quality care.

MR. BERENSON: And I'm going to turn to Mai or the final word to Steve.

DR. PHAM: I remembered. So, I think the future APMs, while they may have to start out with that RBRBS chassis would incorporate fixes to some of the distortions in that chassis and to Frank's concern about a race to the bottom, I don't think that's unavoidable. I think that you can move to a space where you are explicitly rewarding in the financial deal. Historical performance and relatively efficiency and do it in a way that is normative that says and this was one of the things I scribbled madly during the

last panel. We don't talk about what we can afford. That is as least as valid a starting point as what do things costs to generate? We don't talk about what we can afford and we can bring that element explicitly in how we set the prices for these APMs, but I'll tell you the only way we can do that is if the powers that have the market leverage to do continue to exert price pressure on the entire system. Because currently, the counterfactual that providers out there walk around with is, our APMs are a good deal for me or not? Are MIPs -- is MIPS a good deal for me or not relative to what I make today and that is the wrong counterfactual. The right counterfactual should be relative to what I would be making five or 10 years from now based on the policy signals that I am seeing.

MR. BERENSON: Let's give the panel a hand. So, here's the plan. Lunch is going to be served to my left and at 12:45 if you can get back at 12:40, we have a great lunchtime panel explaining some of the international activities and value based payment. It'll be back in this room. It's called a luncheon, but it's actually, you're just back here. So, thank you.

(Recess)

MR. ZUCKERMAN: Hello, welcome back from lunch. In the interest of staying approximately on time while people are filing in, I'm going to invite the panel to come up and start introductions. So when we were putting this program together we realized that, you know, Americans may think, and certainly people working on the Medicare program may think that they know a lot about payment models, but, oddly enough, many people in other countries get health care and many physicians actually get paid for providing that health care.

So we decided that having an international panel would be an interesting idea. And we had a very interesting one set up, as Bob explained. But I happened to be in Berlin this summer on vacation and as people are apt to do, I had beers with our speaker that we had lined up, and we were all set. But more important event overtook, and we ended up having a -- we're having a pinch hit panel, and we're very, very grateful to the three speakers. They responded very, very quickly to our call for an alternative approach. And let me introduce the three of them and get started.

We're going to be hearing about Canada, France, and the United Kingdom. And our first speaker is Antoine Grouix who's the deputy director general of health services and academic medicine in the Quebec Ministry of Health and Health Services. And Antoine is a family physician. He's been

practicing since 2004. Since 2016 he's acted as the deputy general, and has been very active in piloting primary care reform in the hope of improving Quebecers access to timely and highly quality care. And something that Antoine doesn't know is that my mother's side of my family is from Canada, grew up in Montreal, so I'm very interesting in making sure that people get primary care in Quebec.

Our second speaker is Victor Rodwin who's a professor of health policy and management at the Wagner School of Public Service at New York University. And Victor was a visiting professor at a conservatory in France. I'm not going to try to butcher these French names, but he is very familiar with the French health care system and will be talking about that.

And our final speaker, Simeon Schwartz, a name I can more easily pronounce, is the CEO of Optum Practice Partners, a physician management services company, and he's based in London, and has been responsible for Optum's initiatives in the UK focusing on general practice development and new models of care. And he'll be telling us a lot about some of the innovative primary care systems in the UK that are working -- that have been put in place and are working, and the extent to which they are working well.

So we'll be hearing from all three, and we'll start with Antoine, who's got slides and everyone else does not have slides.

MR. GROUIX: So hello everyone. I apologize for the slides, but it does help with the language, so I'm going to make it easier like that. Just a few things to show you a little bit of how things work in Canada. (Inaudible) very healthy, and I don't know about his family, but things are not doing so bad at the inn for some people, at least. As in Canada, as you know, there are things that are easy when we compare it to the United State System. Some other things are not. And some of the things are workable. This is mostly capturing the resource costs is certainly something that is easy in Canada.

As you know we have only one public health system. Well, 65% of the services in Canada are public, so one payer, only. Well, actually, 10 payers, or 12, because we have one system for every single province or territory in Canada, so that makes 12 out of it all. And the medical services are covered by more than 95% overall. And this single payer for physicians who are self-employed is also certainly making things a lot easier.

The target incomes across specialties is something, by opposite, that is really not easy.

Unions share their money on their own, so we have very little impact on making the money go within one specialty or the other, and achieve policy objectives. Well, this is the reason why we are here. Provincial payment schedules are definitely workable, and this is what we're doing. So just to give you an idea of the trends that are going right now, I think this is very, very small for you, and even worse, the circles have moved during the travel. So you can imagine I didn't expect to show you, what about the blank part.

But, anyways, so the idea was to show you how things went from 1999 up to now, 2016. So you see in the blue line up there is fee for service, and it's going down. But since 2008, it has kind of stabilized. And as for APP, which is -- this is also a language trick. In Canada we use APPs for APM, so just make them fit together. You can see that the APM has risen, but at some point, has also get stabilized.

So right now in Canada, now the red circles are right. What I wanted to show is that when you combine a blended system, plus the fee for service, you get almost 84% of the remuneration in Canada that is often that way. And one very interesting thing, as well, that I did not circle, is that incentives and premiums are scoring very high at 0% right now in Canada. So in terms of value-based remuneration, we couldn't say we're really ahead.

Provinces and disparities, the proportion of total clinical payments, if you compare it, so FFEs, once again, fee for service in blue, and you get the orange part for APPs or APMs, you can see that it does vary from province to province. And, behind the grey part of the territories, (inaudible) you get from 13 more or less to 48%, so it gives you an idea of where we're heading in terms of this kind of repartition. As for the physicians' disparities, as well, the proportion receive APP payment really is also varying a lot from 16% to 93% at the top, depending on the province where you are working.

The specialties also have shown very significant differences. If you counted it out, the very right, the surgical specialties, where you see the fee for service as it was (inaudible) earlier, are still very high. On the counterpart, family physicians were working more and more in patient medical home in Quebec and elsewhere in the provinces in Canada really are thinking a lot more about these blended systems of payment or APPs. So, actually, in Quebec, family care especially is putting a lot of efforts into getting its policy objectives realized by including some of this blended system of fee for service, plus something. So we are heading for population satisfaction, which is right now.

And I understood this morning, here, that your issues are likely the same that we face. Better access really is ahead in the ideas of our population in Canada and especially in Quebec since we're very bad at it. And so what we offer right now is a sort of a blended system of remuneration in patient medical home, which we call in Quebec (speaking French). Their rumination there is based on rostered patients, plus an access rate. So it's not capitation as absolutely as it could be, but we're offering doctors, physicians, we're offering them a bundle of money depending on the number of rostered patients they have. And we do add something, and this is unique, as far as we know, to Quebec, of an access rate, which is the yearly visits made by patients to family physician divided by the yearly visits made elsewhere in primary care settings. So that we're targeting an 80% of the visits for one patient to one family physician, which is really what we are, right now, establishing as to basic of this evolution of access.

So we do link that idea of rostering patients that is definitely known and certainly not new, with this new aspect, bringing great value, so far. We've just been doing this for a couple years now, and we have already seen for the very first time a lower number of visits in our emergency rooms in Quebec, which is really significant. Volume and access are both up. Doctors are working more hours and offering more advanced access and access overall in patient satisfaction as a recent survey said, really has also gone up. But, of course, in these kind of strong changes, provider satisfaction doctors at front are definitely more (inaudible).

Hospital I'll go quick, because we are not doing as good in hospital. The police objectives are pretty much the same, but remuneration is really more on -- as you've seen, on fee for service, and what we've tried to do is include some per diem to get to blend system. But this per diem plus FFS without any control or any expectations or requirement, gave a very poor value. We are seeing costs going up. Volume and access are down, and patient satisfaction, we have no clue because it's not traditional to evaluate what patients think about what we're doing for them, especially in a hospital treatment. So this is just beginning in Canada outside hospitals and primary care. So, bad experience.

Orientations really are a little bit in the trend of what you said this morning. We're thinking about this APP, but try to find a simple solution to a complex problem rarely works well. And this is why we're realizing right now, just, obviously as you are all realizing, but nevertheless, we're wishing to

increase the access rate I was talking about to at least 85% as a recent survey also indicates clearly that patient satisfaction by 85% access rate just rise like crazy. So we are expecting to get that target higher.

And I'll stop right there if I want to keep up with this 10 minutes. There you go. Thank you.

MR. RODWIN: Given the time constraints, I know what to do. I will begin with my conclusion, and then proceed as far as I can get. First, the French experience suggests that it is possible to modernize and adapt an obsolete health care system, and contain costs, if that was an objective, within the context of fee for service payment on the basis of a national fee schedule. I won't comment on how well it's possible to do that because I don't know, based on anything I've heard this morning, how well it's possible to do that in any of the many systems I've heard about here. But it is possible to do that, and that's what they're doing.

The second conclusion is that the role of the payer, the National Health Insurance System in France, has evolved as payers have here, except that it's one for the whole country, has evolved from a passive reimbursor simply repaying services after they were delivered to a much more active player in managing patients, patient care, information derived from claims data. And that's a very important transition.

Now context is everything. I remember the first chapter of the PPRC, it was based as well, so I have to say something about the context of the French system. And I remember Bob Evans and his inimitable language once characterized the Canadian system as a bilateral monopoly due to the legislative exclusion of private health insurers from covering the basic package of services, and France is exactly the same. Not only is it a bilateral monopoly, which has legislative exclusion of private insurers from covering anything covered under the basic plan, but also it has an institutionalized national structure of negotiating machinery between the medical profession and the National Health Insurance funds.

Likewise, and that follows from what I've just said, in France, I have to emphasize, there is no choice of insurer. Everybody's in the same boat. You can choose your complimentary insurer, but not for the basic package, no choice of insurer. There may be minor differences according to occupational categories. There are many different funds. It's a multi-payer system, all following the same national rules. So in this respect, France is very different than what one often hears about Germany or

Switzerland or the Netherlands where patients can choose among competing funds. In France, there is no such choice. Everybody has the same insurance for the basic package, but you have complete choice, as in Medicare, on where you get your care.

So paradoxically, France has a much more pluralistic system than the image of a centralized state would lead one to believe, and more pluralistic, I would say, then Canada and Quebec. France is neither an example of socialized medicine like Cuba, obviously, or our Veteran's Health Administration. Nor is France a government run system like the NHS in the UK. It's a national health insurance system which combines large elements of public finance with private provision, largely for ambulatory care, and now I get right to the topic.

Care in the ambulatory care sector is dominated by fee for service paid doctors who are paid according to a national fee schedule based on, believe it or not, 7,000 CPT codes. The French do everything their own way, no American influence. There are no fee adjustments for differences in practice costs across geographic areas. Forty-eight percent, almost half of all physicians in France, work exclusively in private fee for service practice. Forty-one percent work in full-time salaried practice. The remainder work in some combination of both. The ones who work in salaried practice are largely working in hospitals, public hospitals. The ones who are working in private fee for service practice are largely solo-based or group-based, but groups of two or three. That's the situation.

Now there's, unlike Medicare, which is, from the French point of view, a very government run sort of system, there is extra billing. Physicians can be part of Sector I or Sector II. If they're in Sector II, they can charge whatever they like, as long as they charge it with tact and measure. That's never been carefully defined, but that's another topic.

Eleven percent of general practitioners are in Sector II. Forty-one percent of specialists are in Sector II. Seventy-nine percent of surgeons are in Sector II. Fifty-six percent of Ophthalmologists are in Sector II. And in Paris, Lyon, and Marseille, it goes up to 90% in Sector II among the specialties. Hip replacement, I won't even go into.

So the physician fee schedule and its problems. Despite the significant differences between the U.S. and France, and the languages barriers, (inaudible) that have hindered cross-national understanding with respect to Medicare, France, no less than any other nation, has been strongly

influenced by innovative administer of technologies born in the United States because we're the country of innovation. Every panel this morning, every member of the panel, talked about how innovative they were. And conceptually, I have no doubt about it.

They were strongly influenced by DRGs and now reimburse all their hospitals on the basis of DRGs. They were strongly influenced by the work of Bill (inaudible) and the Payment Review Commission, PPRC, and over the course of the '90s, they came up with their own RBRVS. (speaking in foreign language) technique, CCAM, with 7,000 codes. Since 2002, when this schedule was put in place, there's been very little change and very little update, and that's the process.

So I have two minutes and I will summarize key points. First, the update process, very complicated, as you can imagine. But it is done through a commission called the SHAAP, with 16 members, partly from the National Health Insurance Fund and partly from the specialty societies, the trade unions nominate specialty society members and they take a random selection, and they fight it out. They do studies, but they're not as science based as what Paul Pickens version would have us want, or anything comparable to what we did here. There's much more of a concern about incomes policy and what's the right amount given the income's policies.

Two key problems. First, nothing has been done since 2002 to update the scores of the CCAM procedure codes through the update process. And, although they've agreed that they should reduce overvalued procedures and increase undervalued procedures, they have been far more successful - big surprise - in increasing undervalued procedures than in decreasing overvalued procedures.

Second, practice costs have not been updated. This is the agenda for this coming year. And they will be updated, but there's a big discussion, as you can imagine, on whether it should be updated based on observed costs or based on what the costs should be if people modernized their practice and took advance of everything we've heard about this morning.

What works in France is the system of institutionalized agreement every five years where they meet on a regular basis and hash this stuff out. In the final minute on recent developments and challenges in France is that they've tried to encourage the growth of health centers by paying lump sum fees to set them up all over the country. They've tried to encourage coordination functions by having

lump sum payments for transitions out of the hospital and back to care for maternity, back home. There are different programs here. They've tried to increase payments, and they have succeeded for chronically ill patients, so if you take care of an 80 year old who's got all kinds of conditions, you get 80 euros on top of what you got as a whole barometer of fees. They've tried to improve access to care for physicians in Sector II.

They've increased fees for complex consultations based on the profile of patients and their characteristics. And, last and not least, they have had a pay for fee program influenced by their neighbors across the channel. But they've used it differently. They have 940 points with a whole series of measures and composite scores. The doctors don't know when they will be remunerated more or less. They find out at the end what they've done based on the information on them. And that's where they are today.

So I come up with the conclusion that I came up in listening to this morning's meeting, which is that this is really a false dichotomy, what Bob Berenson has given us. It's not a question of one or the other. It's a question of both, and they're doing both, and we need a lot more work. I'm working with Miriam Laugesen and Michael Gusmano at Columbia University on a study of Japan, Germany, and France. And we've just started doing interviews to see how they are going to manage to change that system and bring it into align with the demands of 21st Century medicine while maintaining a fee schedule and using lump sum payments. I'm sorry to have gone over the timeframe.

MR. ZUCKERMAN: That's all right. Don't worry. Thank you. So now we are going to move across the channel and see what -- who the French have been learning from. And so the National Health Service, as I understand it, has been paying GPs based on capitation and doesn't really use a fee schedule the way France does. So I think it would be interesting to kind of get a sense as to, you know, how satisfied policy makers are with the capitation, whether it leads to stinting of care or possibly -- especially referrals. And then we'd like to hear about the UK's QOF, the qualify outcomes framework that is a very, very large pay for performance initiative that has been mounted in the UK. So turn to Simeon for some insights on that.

MR. SCHWARTZ: Thank you. I think I can make two conclusions about this audience today. The first is, judging from my accent, you can probably guess I'm not native to London. The

second is that you probably all have an opinion about the NHS, informed or not. And there are a lot of reasons for that. The NHS comes up in politics all the time. And you might be shocked to hear that there's actually good and bad.

Let me start with the bad first. It's funded at 7.3% of GDP. So one of my cynical friends used to say that for every price there is a service. What I learnt in the UK is that for some prices there is no service. And that is really a problem that access becomes impossible within what some organizations within the UK are paid. If you have a rash and you want to see a dermatologist and your GP sends you to see a dermatologist, the average wait now is in excess of 18 weeks. Either the rash is gone or you're dead by then. It's really very straightforward.

And the hospital sector is massively inefficient. The length of stay in one of the hospitals we've been working in the area where we've been, north of London, for the Medicare age population averages 9.8 days, compared to 4.9 days at WESTMED. And their incidence of (inaudible) to infection follows along with that lengthy stay, also. It is not only that they spend a lot of time, but they also spend a lot time in a dangerous environment with other five patients in their ward, hopefully of the same sex.

So the American public really is not going to accept what is funded by the NHS and the investment that they've made in what they call secondary care, which is specialty care, or in hospital care. It's rather interesting, by the way, parenthetically, that if you have a heart attack or you have a stroke, they actually have pretty good systems for getting you organized to the right place at the right time for the right care. And in areas that they've concentrated on, they've been excellent. And I'd also say that, for those of you who are not familiar with NICE, which is their review organization for approval of services, it's a remarkable model that the vast, vast majority of physicians agree makes the right decisions as to what services bring value and don't bring value, and allows for a national system of value. So that's the good and the bad of the general system.

I'd like to spend my next nine minutes on primary care and what's happening in primary care. So in 2004, there was a reform for primary care that went to a fully capitated payments for a bundle of services which are most of the primary care services. And in addition to that, there was QOF. QOF says (inaudible) stands for the Quality Outcome Framework, and today it includes 556 points. There are over 100 parameters in QOF. The vast majority of them are process parameters. And I would actually

rename it as Q-P-F where the P stands for process. Unfortunately, I can't figure out how to pronounce that. So we'll continue with QOF for the time being.

And the average physician in GP who wants to stay and survive in practice is currently getting about 90 plus percent of their QOF points. Many are getting in excess of 95%. And it now is about 25% of their income. So the average GP in the UK is currently getting somewhere in the range of 90 pounds on a capitated basis, which is carefully adjusted, by the way, on this formula, which is secret, so they have to shoot me if I disclosed it, but that determines the capitated payments based on a patient's age, demographics, whether the patient's institutionalized, like in a nursing home, et cetera, and what their socioeconomic status is. It all goes into determining what your capitation level is. So that's your base capitation. And then you typically earn somewhere in the range of about 30 pounds or 35 pounds form your QOF points.

What happened was, when the government put this in in 2004, they budgeted the average physician to accomplish somewhere in the range of 70 to 75% of QOF. Their budget was broken within two years, as physicians basically did exactly what you expect them to do. If you pay them to do things, they do exactly what you paid them to do. And therefore almost everybody was able to get their QOF over 90%, much to the surprise of everybody. So the single most important lesson in QOF, and QOF is exactly what you'd expect, right? You know, did you do the blood pressures, blood pressure controlled? Did you get a hemoglobin A1C for diabetes? Give aspirin, you know, for someone's who has a heart, all the usual parameters that you would accept, and these have all been reviewed by NICE and by the British Medical Association, which negotiates on behalf of the GPs for their five year contract renewals.

So that system has been in place and the problem is is that - and I'm sure most of you recognize the problem - this doesn't get you coordinated care. It gets you flu vaccines. It gets you, you know, Pneumovax. It gets you a PAP smear. And I'm not minimizing any of those things, all of which are extremely important, and I'd suggest that they have a much higher rate of the public health type interventions than we have here because they focused on these things. But what they don't have is coordinated care for sick patients. And that really is the biggest problem that they face. And they've also faced the problem of how to reform the hospital sector.

So what you've learned from the GP experience, and we call it the three I's, which is, it's based on having the right information about the patients. It's second I is infrastructure. The GPs get forms. The only two major EMR vendors in all the UK, every year, those vendors come out with new QOF forms that are templates that match the QOF requirements. In their EMRs they have their registries of who is in which category for QOF. Every time a patient is launched in the system, a popup comes and tells you what QOF is missing, and almost every GP practice has a QOF coordinator whose job it is to keep it going.

So what they have is very good infrastructure. The government takes the QOF data out of the EMR every single night, and de-identifies it. So their QOF is up to date every day, and the government (inaudible) every day. You know exactly how much money you're going to make in QOF. Every single day of the year you know exactly where you need to go. So infrastructure, in addition to information, was extremely important. But the third I is incentives, and getting the right incentives. If you don't pay enough (inaudible) behaviors, you don't get the incentive you want.

So I think there's a lot to learn about the kind of information, infrastructure, and incentives that are necessary within the -- in order to accomplish these kind of quality initiatives. And be very careful about how you choose what metrics you want, and how you're going to accomplish those. Lastly, what am I doing in the UK? So two things I'm doing. First of all, GPs are going out of business because the total payments to them is inadequate and basically it's cheaper now -- it's easier now to be a non-partner of a small practice and just go work for somebody. The whole concept that GP practices are owned by their partners is falling apart because of poor payments.

And the other reason is is because they're small businesses, and they're not run at scale and they're not efficient. So we're in the process of building what we call a GPMSO, which is an organization that will help the GPs run their practice at scale, improving their analytics and improving their performance. And it's been very well received and we will launch the first of the year.

The second thing I'm doing which is actually is more interesting, is we're beginning to look at how do you build ACOs in the UK. And there was enormous political movement to do this. And once again, the hospital acute sector has come up with a million reasons why it can't function that way, but the country is now divided into 44 STPs, and those are being divided into health areas. So the STPs

have about a million people. The health -- and with some governance over the payer mechanism, those are being broken down into health economies which average about 250 to 300,000 people, which will be the primary delivery units for ACOs. And the physicians are being encouraged to aggregate, the primary care physicians into the (inaudible) medical homes that will have 15 to 25 GPs per unit, and they'll care for anywhere between 30 and 50,000 in population.

And actually, if you think about that from a capitated standpoint, that is a very, very efficient organization, and people expect that over the next 5 to 10 years, the dominant mechanism of payment is going to be into these middle sized units, and the predominant GPs. QOF will go away and be replaced with local mechanisms for payment of quality within these individual health economies.

So I'll stop at that and I'll take any additional questions if there are some.

SPEAKER: So thank you. So I'm --

MR. ZUCKERMAN: So I'm going to try to leave time for the audience. I am sensitive to the time, but I want to come back and ask Antoine one question. So I noticed from your slides that it looks like there's a lot of variation across the provinces in who relies on the, you know, on the alternative payment models. And I wanted to get a sense from you if you can say what the conditions are that in some provinces relative to others that are leading to greater reliance on the alternative payment models.

MR. GROUIX: That's a good one. It's difficult to say that there is one province leading. We kind of have 10 very, very tiny United States of America on innovating very actively, but not spreading what their innovations are across the country. We're not doing so much transformational knowledge transfer and this is certainly an issue we're facing. So it's difficult to say that, for instance, Ontario or Quebec is a leader.

For sure different innovations like the ones we're doing in Quebec with (inaudible) of certain patients more vulnerable patients, and giving bigger bundles for taking care in terms of capitation of these patients is an innovation. Another one is the one I presented with this access rate. This is also very inspiring for Alberta and Ontario, and we ourselves inspired ourselves with initiatives made in Alberta and Ontario. So it's kind of a blend of different leadership sectors in different provinces. But I could hardly say that we really have one very specific leader somewhere.

So these differences really are showing the diversity and the unique character of every

single health system. We really have a very, very (inaudible), unlike France, for instance, that really have this broad system, this broad and general system, for the whole country. We do not have that in Canada. It really is separate.

MR. ZUCKERMAN: You know, I guess I was asking because I won -- (inaudible) problems but -- (inaudible) provinces that (inaudible).

SPEAKER: On the other hand, (inaudible). In another sense, Canada is more -- France is more pluralistic, I would say than Canada. In some senses France is more pluralistic than Canada. There are private, for-profit hospitals. One-quarter of hospitals are private, for-profit. Nothing like that in Quebec. The others are public. You have fee for service. You have health centers. You have outpa-, you have a whole -- a very pluralistic set of arrangements which are far less, and, in fact, centralized. But with the fee schedule, that's centralized. But that's centralized in Quebec, too. Isn't it? Just --

MR. GROUIX: In Quebec?

SPEAKER: In Quebec.

MR. GROUIX: Yeah. We prefer --

SPEAKER: But not the other (inaudible).

SPEAKER: There is no --

MR. GROUIX: In other words, there's no national fee sche-, payment schedule. There's no --

MR. ZUCKERMAN: No, that understand.

MR. GROUIX: -- Canadian fee schedule.

MR. ZUCKERMAN: No, that I understand. I was just thinking about across the provinces.

MR. SCHWARTZ: Yeah, I would add one interesting thing, by the way. One of the reasons that costs are low in the UK is because they're unit costs are low. And one of the problems in the U.S., particularly outside of Medicare and Medicaid is that unit costs are ridiculous. Right? So, you know, one thing you can learn from some of these countries is that they have national systems for unit costs. So even if you don't want Medicare for all, maybe you just have the Medicare fee for all.

MR. ZUCKERMAN: That's certainly an idea that has been talked about. So --

SPEAKER: (Inaudible)

MR. ZUCKERMAN: Yes, it's called all payer rate setting. That has been considered. So I'm going to ask just one very -- two very short questions, one for Victor. So Sector II, it's kind of very interesting to me. I know it's kind of settled law in the United States that Medicare is not going to allow balanced billing, but it sounds like balanced billing is allowed in France. So has that --

MR. GROUIX: With tact and measure.

MR. ZUCKERMAN: Yeah, with tact and measure. So with tact and measure, has that created any access problems? So certain populations feeling that they're excluded from certain providers who, you know, maybe are not quite as tactful and measured as they might be to certain populations?

MR. GROUIX: No, it's a big problem. I mean, everything is relative. It's a big problem within the hexagon. It's not a big problem when you compare it to the United States. So what in France, it's a major problem and many steps have been taken to deal with the problem. For example, in this latest agreement from 2016, those physicians in Sector II are given higher rate increases if they will take care of certain categories of patients who are equivalent to our Medicaid patients. I mean, to the extent of 1 or 2%, so the magnitude of the problem is much smaller. But so measures have been taken in this way and also to promote access in areas with underserved physicians.

Also there have been limits placed on how much extra you can charge. When tact and measure didn't work there were some guidelines about not more than two times, maximum three times, the assigned fees.

MR. ZUCKERMAN: Now that's a lot more room than Medicare has. And in terms of, you know, not getting coordinated care from the QOF, but is there evidence that there's improved health outcomes? Is the population getting healthier?

MR. GROUIX: Unfortunately you (inaudible) right now. The population is following the same trend in the United States, which really is a crisis. The non-college educated working class, middle age, is dying faster. So it's very, very similar to the same health data in the United States through combination of alcohol and substance abuse and some other traumatic events. So the global health policy issues in the UK now, because of that, so yes, if you make it to 75 in the UK, you're probably okay. But if you're between 40 and 55 and you're a, you know, a white male who is not well-educated and was

in one of the rust belt industries, you're in trouble. So that's become a big focus of the health care policy. But in terms of really, is the population healthy, as a result of that? There's really no great evidence for that.

MR. ZUCKERMAN: Questions from the audience? Katie, and then --

SPEAKER: Do you need a microphone?

SPEAKER: I don't need a microphone.

MR. ZUCKERMAN: She doesn't need a microphone. I know (inaudible).

SPEAKER: They make me use it anyway. So Simeon, as someone who's spent a bunch of time in the UK off and on over the last 20 years, one of the things that impresses me, and this is among people my age and older and somewhat younger, well-educated, high achieving, an incredibly strong devotion to the NHS, and an incredible pride in the NHS, and I literally think it goes back to, like, the war. And, like it's the -- it's what came out of the ashes of, like, a horrible period of their history. And even rich people who can afford better, stay in it. And I feel like that has a lot to do with something about what it can and can't do. And I don't know if, A) if I'm overstating it, and B) if you think that informs what the toolkit looks like, just the national commitment to the enterprise.

MR. SCHWARTZ: And that's absolutely true, by the way. The public, historically, has loved the NHS. They don't care that they're six (inaudible) wards. They don't care they wait 18 weeks. The government's going to take care of me, and I pay nothing. And, by the way, it's first dollar coverage. There's no copays. There's no nothing. Patients love that. Big success. The problem is, is that the millennial generation that is now coming up does not have the same love for the NHS. Twenty percent of the population already had private insurance. That wasn't present before. And the third problem really is, is that their total scores are now going down for the first time, and there's enormous pressure on the government to fix the system, which they see in crisis. And actually, right now, just before I left London, there was a comment, and I remember, by which member of parliament, but that the number one health issue now, the number one political issue in the UK is not Brexit. It's the NHS. So that gives you some idea for their sense of crisis at the moment.

SPEAKER: Thank you very much. We hear a lot in the States about the expense of going to medical school through being an intern, through being a resident, and how that impacts on the

type of doctors that result less primary care doctors, more whatever. I wondered if each of you could talk about the mechanisms in place for generating doctors, and how they're working.

MR. ZUCKERMAN: Who would like it?

MR. SCHWARTZ: (Inaudible) in the UK, by the way, all physicians are paid very similar amounts of money, so there's not a huge economic incentive. In fact, actually, if you're a entrepreneurial physician, you can make your most money being a GP. The problem is is that no one wants to be a GP for two reasons. Number one, the rest of the medical profession looks down on you, and there is really a bad culture about that. And the second problem with being a GP is that the daily work is unbelievably challenging and stressful. The specialists in hospitals have a lot of opportunities for coffee, early time to the bar in the evening. It's a much better lifestyle.

SPEAKER: The pub.

MR. SCHWARTZ: The pub, I'm sorry.

MR. RODWIN: There's not the problem in France of debts for medical education that you have in the United States, so that doesn't play in at all. But since the fee schedule is so similar to our free schedule, if you want to make money, you go into the specialty services, the most highly paid categories. And the fee schedule, as the French see it, is not just about science and the proper value of the fee, it's about incomes policy and what you get paid as a physician across specialties. So it is well known, radiologists six, seven years ago were in the most highly paid profession, and eventually, through the negotiations and through some state intervention, as well, those fees were brought down for the radiologists. Now the anesthesiologists are the highest paid profession, and measures will be taken, probably by the government, because they don't work out in negotiations to lower those fees, as well. So the incentives are there still to go into the specialty services in France, but you have over 50% still as GPs. So it's not as severe as in the United States, although it depends how you define primary and specialty care in the U.S.

MR. GROUIX: In Canada, medical studies are very cheap, as you might know. If you're Canadians and go to med school, it's whatever med school you choose, it's almost all the same, and more or less $5,000 a year for the number of years you're studying medicine. So the issue is not there. Afterwards we get much closer to the UK where we have -- it's not a matter of having differences. Well,

they don't. We do have huge differences between GPs and other specialists. We really are -- there's a gap. It's almost twice as -- the earnings are as twice as -- are twice bigger for other specialists than for family doctors.

But, and definitely the (inaudible) for family medicine in Quebec and Canada, large, really is lower because of that gap. Mostly because, at some point, fi you hesitate between cardiology and family medicine, you'll say, okay, I like both. This one is going to bring me a half a million dollars a year, the other one a quarter million dollars a year. Well, who's stupid enough and say, okay, I'll go with the quarter. So it's kind of an issue that's not really happening, but it's -- this is what happens (inaudible). Over the last, we do have issues of interesting family doctors and two family medicine now days, but mostly because of this issue, and not because of the -- this historical relation between family physician, other specialists that looked a little bit like what's happening in the UK, but is not happening any more. We don't hear so much in the younger doctors. We can hear it in older doctors, but in younger doctors, they do recognize this load that our -- that family doctors are taking on their shoulders, and they do recognize this quality of life thing that is definitely more difficult for family doctors than other specialist. So these are the issues I'd say, (inaudible).

MR. ZUCKERMAN: Okay. And one last question from Eric.

SPEAKER: Okay, thank you. This should be brief. To Simeon about the UK, two things. One, the mortality amenable to health care in the UK before 2004 and 2014 dropped faster than 11 countries, high income countries.

MR. SCHWARTZ: I'm sorry, one more time, please.

SPEAKER: The mortality amenable to health care in the UK dropped more than 10 other countries in high income class between 2004, 2014, so I think there is some evidence that they've made gains. The second observation is that they've been shrinking their national health spending budget year over year, which is unimaginable, I think, in most other countries. And I'd like you to comment on that context. And then the third is coming back to our theme of today. As they move to ACOs and other, kind of, management intensive approaches to delivering health care, are they considering creating service code, fee schedule, like resource management systems and what will those be based on?

MR. SCHWARTZ: So thank you. I didn't know that data. Thank you for that data.

Second of all, I'm not aware of any interest in creating -- remember, all the hospitals and specialist care are already on fee for service. Right? They're already paid. And, needless to say, there's no shortage of services provided. But my understand was that they were up over 9% of GDP. So they've contracted about 25% in the time when the economy has grown, as you know, nowhere near the pace that they have liked. And the interesting thing is that when the Labor Party ran on a, you know, on various NHS reforms. None of it was proposing a higher percent of GDP to spent on health care.

So I think that the emphasis is really on moving to more efficient systems, because the unit costs are very low. So if you think about that, if your unit costs are low and you don't think you have -- there's no evidence that they provide more services than we do. Right? So if your unit costs are low and your service volume is contained, either by rationing or by access or whatever else you want to do, then the only thing you can really do to improve your system is improve your efficiency and your coordination to care.

MR. ZUCKERMAN: Okay. Please join me in thanking these panelists. They did a great job on very short notice. We're not taking a break now. We're going to move right to the next panel, so you'll have to tolerate hearing from me again.

MS. MERRELL: Welcome to Session 3, the famous Session 3. And I just want to follow up, I didn't mention to Simeon -- I don't know if you guys saw the headline coming out of the UK a couple of days ago, this big study that said sleep deprivation is the single biggest health threat and the biggest way to save money is to get everybody in the UK to sleep longer. And I just wanted to share the results with you guys of a study I've been conducting for 25 years that they could totally benefit from, which is if you say the word practice expense people go to sleep. (Laughter) So I feel like we have a lot we could go where with that. And I just want you guys to prove me wrong.

So we're going to talk now -- this is called the "research session" or technical session. And these three are bravely going to talk us through some research related to the physician fee schedule. Joe is going to talk to us about prices and why they matter and then Steve is going to talk about work and some research that he and with others, have done about that, and then Peter Hussey, bravely, from RAND is going to talk about practice expense and the challenge we all face -- no fault of Peter's (inaudible) I'll fall asleep -- and I'm tell you it's hard. But we are missing Antoine. And -- oh, hi, he's sitting

up here too. You want to come sit up with us? Yeah. He didn't want us to watch him sleep, he was going to sleep in private. We've invited him to join us on this sort of technical thing (a) to add anything he might want on sort of the more technical aspects of what they do and on their fee schedule, and also possibly to respond to some of the issues and topics that get raised here. He will say a lot or a little as he is moved to by the time we get to that. You can tell that part hasn't been as planned as the rest.

So, first, we have Jo Newhouse, who is well known to many of us here. He's a Harvard Professor with a long title that I'm not going to say -- sorry -- and so many accolades that you just have to read them, but the one that's salient, besides his work as health economist, is that for several years he was the Vice Chair of MedPAC in the '90s. And there's a lot of ex MedPAC here one way or another. Second we're going to hear -- as I said, he's going to talk about prices and why they matter, why we care about them, and evidence about that. Steve Zuckerman is the Senior Fellow and Co-Director of the Health Policy Center at Urban. You've already seen him, he moderated the previous panel, but he did not introduce himself to you then. He will talk about work. And then Peter Hussey, who is a Senior Policy Researcher at RAND and the Director of their health services delivery system program and a Professor at the RAND graduate school. And he's going to talk, as I mentioned, about practice expense and you guys are going to be admirably attentive. And then, finally, we'll hear some more from our lunchtime speaker about how this stuff plays out in Quebec.

So I'm going to ask Joe to start, and I know he has slides here. Thanks.

MR. NEWHOUSE: Well, I wondered about scheduling a technical session right after lunch. When I was on MedPAC we always used to see who drew the short straw by who would present right after lunch because the commissioners would be falling asleep.

So let me dive into it. I'm going to follow the dictum of the person I think who said they would put their -- I think it was Victor -- put their conclusions up front, so in case you do fall asleep you will at least have seen them. As Katie said, just talk about some evidence on how the levels of fees matter, talk about why there are kind of inherent problems in a pure fee-for-service system, and then where I would head. Bear with me.

If you've taken economics this should be somewhat familiar. If you haven't, all it says is if you change a fee level, let's say increase them, we don't really know whether -- a priority -- whether that

would increase services or decrease services. Somebody said they'd taken Economics 101 and if you decrease them it should decrease services, but I'm about to show you that isn't so, at least empirically. So this comes from PPRC -- maybe Paul and Katie, and Lauren if she's still here, will recognize it -- this was actually from the implementation of the RBRVS in 1992 and the PPRC staff looked at what happened to service where the unit observation was a state-specialty. So the slide says like cardiologist in California. And what they found was there was in fact the negative relation. If fees -- so fees went up for -- as was said the morning -- for the E & M services, tended to go down for procedures. Things that went down, there was more of after the fact. So if fees went down about three percent the estimate here is there was about a one percent offset. And this, unlike most of government scoring, actually became enshrined in the CMS actuaries estimates of what proposed legislation would do for Medicare spending.

Okay, second study. 2005, Medicare makes a really large change in how it pays for cancer chemotherapy. Markups on cancer chemotherapy by the oncologists were roughly half their income and their income about that time was ballpark around $400-500,000 a year. So you see the red line there is a fall in carboplatin and the yellow is a fall in paclitaxel. And so these fees went down by on the order of a factor of 10 from over $2000 to down under $500. So a big change, big change in come. We looked at what happened with lung cancer patients. Roughly 10 percent more of them were getting chemo after the change. Fees went down, more chemo. Now, the usual instinct is this is probably a bad thing, induced demand and so forth. Well, here -- I skipped over it but you can also show that if the fee change causes a big change in income that the effect seems to go the opposite way, the fee change. If it causes a small change in income, then it goes -- the direction will be if there's a small change in income fees go up, because they need to do more of it, and vice versa. So here there were more patients getting chemo but physicians started to treat them with agents whose relative price went down less. That's what is showing.

And unusually after this change mortality went down among lung cancer patients among the elderly. And there is some discussion in the oncology literature that oncologists were under treating the elderly. This is not quality of life you'll notice, it's just mortality. But still we thought this was very interesting.

There's a third study. We haven't heard much about geographic variation in prices. This

morning there was some mention of urban rural in the first panel, but I think it's fair to say that how Medicare varied fees geographically was rather haphazard. Really, some would say it still is. Basically to get political implementation in the '60s Medicare let state medical societies decide geographic areas for Medicare, geographic adjusters. CMS changed that in the '90s. It moved counties around. Fees changed not a whole lot, basically a range of -4 to +4 percent. And that was studied and lo and behold now a big positive change with fees. Every one percent change in a fee increase elasticities went up, or the amount went up one and a half percent.

So, those are three pretty clean -- in my view -- natural experiments on fees. All of them show that fee changes matter to what is delivered. They do vary in the direction of the sign. The first two fees go down, procedures go up. The third one, fees go down, procedures go down -- or services go down I should say, not procedures.

I'm going to talk in a minute about joint costs and why 100 percent fee-for-service system is so difficult to manage. So Peter's going to talk about practice costs, but the basic idea here is that it varies across specialties, but on average around half of physicians' revenue goes to the physician as net income and around half goes to so-called practice expenses. Now, some of those practice expenses are what economists call joint, meaning that you can't allocate them uniquely to a given service. So if the physician is paying rent for their office space that's going to have to get reimbursed or the physician goes out of business, but it gets reimbursed by basically spreading it around to various CPT codes. And that -- basically an arbitrary allocation and it means that (inaudible) setting aside the physician's time issue, the physician can always earn more income by doing more because the add on for those costs in the fee is going to exceed the cost of doing the service. It was rightly said this morning that fees for service aren't reimbursed. There's less of that. But so the physician -- for the services that are reimbursed the physician can basically earn more by doing more. And then therefore what I've been pushing for, longer than I would care to contemplate now, is what economists would call a two-part pricing schedule, which is a somewhat jargon-y version of the medical home or what people were saying as paying a per member per month charge with a fee on top of that. Because if we worry about joint costs being allocated to services and therefore giving an incentive to over serve, if it's a pure capitation in theory we ought to worry about incentive to under service since marginal revenue is zero. So somewhere in the middle

sounds about right.

And I think that's my last slide. Oh well. Just in case you feel asleep at the beginning but woke up by the end (laughter) there is the takeaways again.

Okay, thanks. (Applause)

(Technical difficulties)

MR. ZUCKERMAN: Thank you. So when we were organizing this program we decided that we wanted to have a session on research. And I think we basically thought about it, it was kind of forgotten research. Paul pointed out, you know this morning, that this is scientific approach to determining relative values and there's three components to the relative values scale, work RVUs, practice expense RVUs, malpractice RVUs. No one got assigned the task of talking about malpractice RVUs. Peter is going to talk about practice expense and I'm going to talk about work RVUs.

And just to kind of remind people what you heard this morning, there's several components to work RVUs. The key focus that I'm going to be staying on today is time, but then the other components, technical skill, physical effort, mental effort and judgment, stress, that all comes into what people call -- what Paul alluded to this morning -- the intensity of the service. And that's the core concept behind -- the intensity and the time are the core concepts behind the work RVUs. But if you think about work RVUs, or any service in fee service, what are you actually paying for, what are you actually valuing. So the unit of service becomes a fairly important concept when you think about how to value services within a relative value scale. So I'm going to touch on issues related to some of the CPT codes, global surgeries of different lengths for services, and then composite services of a specific duration. We've heard some people talk already this morning about the chronic care management code. So that's what I'm going to get into.

So the first thing to ask ourselves when we think about work RVUs is is time measurement accurate. We have time and intensity. Intensity we really can't observe, but we're going to see it's analytically important in a moment. So is time measurement accurate? Why is that an important question? Well, time explains 70-80 percent of the variation in work RVUs. So getting it right is important. And as Joe mentioned you have indirect expenses that have to get allocated, these joint costs that need to get allocated. And time also factors into the algebra that no one will have to see today, I

promise you, that goes into how you allocate practice expenses across services. And the time measures that are used in assessing work RVUs, both by the RUC and by CMS staff, if there are errors in that time measurement and if they're not random -- now remember, if everything is inflated by 10 percent in a relative value scale, that doesn't matter. But if some error -- if some fees are -- time is inflated by 10 percent, others 30 percent, and others by 100 percent, then that's going to lead to errors in both the work RVUs as well as the practice expense RVUs.

And in the tradition of this conference, I'm going to give you my conclusion in advance also and say that the research shows that there appear to be errors in physician time that are not random across services. And what that means about changes in work RVUs relates to assumptions about this concept that the RUC is very familiar with, intra service work per unit of time, intensity. And I'll come back to intensity shortly, because that's, as I say, going to be analytically important.

Now, I'm going to run through -- as we've said there's forgotten research -- I'm going to run through just some very fast results about time estimates. So early on NAMCS data showed that Medicare times for visits were greater than survey times, about a 9 percent difference for established patient visits, 32 percent difference for new patients. OR logs suggested that 40 percent of surgeries were different from the times that Medicare was showing by about 30 minutes or more. Now MedPAC examined this issue -- Mark Miller I think talked about it this morning -- in the context of studying physician productivity and found that the fee schedule overestimates time spent by physicians in total. And if you think about just a little spreadsheet lists all the CPT codes, all the number of times a physician does it, the Medicare assumption of the amount of time it takes, multiply those together, add them up, and some physicians are working about 200 percent of the amount of time that they actually work. So that was strong indication that time was overstated and in fact more so for specialties that are procedurally oriented. And some work that Katie and I did with some other people at SSS found a similar analysis and also showed that if you survey physicians just to ask them about times, that you also see that the Medicare times and the fee schedule are overstated.

So more recent evidence, there were two independent studies that CMS sponsored based on the fact that MedPAC had decided that it was going to be possible to actually get better data on time. And so CMS sponsored two studies, one in 2015 that RAND produced developing a model of work

RVUs based mostly on non CMS data. And it found that 83 percent of surgeries had shorter intra service times -- so that's a new concept I guess. We might want to define it for anyone not familiar. Intra service time is sort of in surgery this notion of kind of skin to skin time, not exactly, but kind of where you're actually in contact with a patient. 83 percent of surgeries had shorter times than exited in Medicare. Now, in 2016 the Urban Institute, RTI, and SSS collected data on physician time, a second study that CMS sponsored, for 60 services from 3 health systems. And for anyone who is concerned about the effort involved in collecting this kind of time data, I can assure you it's not easy. Which is one of the reasons why we ended up looking at only 60 services. We didn't look at E & M services, because E & M services are kind of heterogeneous. But what we found is that Medicare times were greater than 10 percent above the times we observed for 42 of these services and they were 10 percent below for the (inaudible) services. So within the procedures and surgeries that we looked at we found evidence of higher fees, higher times in Medicare than exist. And in fact if you look across the different types of services, for office based procedures we found that times in the fee schedule were about 11 percent overstated. In outpatient surgery centers they were about 35 percent overstated. The inpatient period, inpatient surgeries with global periods were about right. We didn't find, you know -- where you go into an OR those times in the fee schedule are on average about right. Imaging and other test interpretations were 238 percent of what Medicare is assuming in determining relative values.

Now this graph, for those who want to make sure that this is the research session, this shows a plot of intra service intensity. So based on Medicare times relative to intra service intensity using the empirical time. And because our times were lower than Medicare times -- this is just the ratio of work RVUs to intra service time. You see that intensity within the fee schedule is being overstated because times are being understated. And none of this reflects post-operative visits, which I'm going to come to in a moment.

And just to make this a little bit more concrete for the clinicians in the room, we selected five services that all happen to have the same intensity in the current fee schedule, an intensity of .07, so work RVUs relative to time .07. And you can see that for some services the empirical time we observed is greater. For treatment of a thigh fracture it's about the same, for laparoscopic cholecystectomy it was a little bit lower. Again, much lower for hip replacement, and in proportional terms, much lower for an MRI

of the brain stem. So anyone sitting there looking at these five services might thing, hmm, should these all have the same intensity. That's a question to ask analytically. But what we find is when you look at the actual empirical times you find that intensity is much higher for MRI of a brain stem than for partial removal of a colon, or any of these other surgical procedures, where I think kind of intuitively you might think the intensity is in fact greater than interpreting an MRI of a brain stem without dye.

So the reason intensity is an important concept, because if you believe the relative intensities are right then in the fee schedule then shorter times would imply much lower work RVUs for those services. If you believe the intensities are not right with the empirical time then you would actually think that the work RVUs are correct.

So I'm just going to talk quickly about unit of service. And I don't really want to talk that much about this, but basically what the results of our study -- we reviewed with clinical panels, the content of what people assume is occurring in a CPT code. And the bottom line is that the services were not defined very consistently. There was more detail for some services than others, which tend to exaggerate certain time. Some of the descriptions that the RUC uses that go back maybe 25 years describe activities the physicians are no longer providing on their own. We heard a lot about team based care this morning. Well, team based care may mean there's less physician work in a service and more non physician work. Could be clinical but still non physician, but that would affect how RVUs are allocated. In some cases pre-service work is included, in other services it's not. And sometimes the vignette, which is kind of the more clinical presentation of the service descriptions, are not really consistent with the typical patient.

But this is really the slide that I want to -- the issue I want to focus on, and maybe conclude with this, the unit of payment for global periods of surgery. So anyone that understands the fee schedule knows that this new excitement about bundled services really goes back to 1992. Because surgeons, especially for 90 day global periods and 10 day global periods, the number of visits that were provided just immediately pre op and then post op follow up visits were all included in the fee for a service. But studies have shown that surgeons often provide a lot fewer visits than are assumed resulting in unnecessary payments. So we know that you can carefully define these bundles, get a lot of input from providers, and still have bundles that are not accurately reflecting the services that are being provided.

RTI did studies on this, GAO did studies on this, RAND did studies on this. In fact RAND estimated that there would be about a 22 percent reduction of physician work by eliminating these -- I guess what I would call phantom visits. And in 2012 that would have saved Medicare about $1.5 billion.

Now CMS recognized this. This was not a place where research was forgotten. CMS tried to address this problem by acquiring separate billing for all the medically necessary visit, and they were going to do this by 2018. However, MACRA, that introduced the doc fix, got rid of the sustainable growth rate, stopped that payment change. Might have been one or two physicians in the country that contacted one or two members of congress and so now this payment policy change is really resulting in CMS along with RAND trying to collect data on visits so that they can prove the valuations.

And now I'm just going to conclude by saying, you know, there have been a lot of services added to the fee schedule that really are kind of duration based services where you're seeing things that don't require face to face interactions with the patient during this service. And it's really part of the effort by CMS to address the concern that RBRVS does not adequately compensate for primary care. So you see just some examples. Chronic care management, in a month, they're now paying for complex chronic care management and transitional care in 14 days after a patient leaves the hospital and for higher complexity patients for 7 days. So you're beginning to see the fee schedule add codes. I know there was a debate this morning between adding codes or alternative payment models, but certainly CMS is pursuing the idea of adding codes like this.

So I'm going to stop there and hear about practice expense RVUs. (Applause)

MS. MERRELL: Real quickly, while Peter's slides are getting set up, I just want to tell everybody that there's a bibliography available on line that includes the citation from everybody's slides up here as well as some other materials that people who found this interesting may actually find those other materials interesting too, but maybe not. Anyway, that's available on line at the same site that you went to to register for this.

MR. HUSSEY: Okay, thank you. It's a real pleasure to be here to talk about practice expense. And it's not naptime. I'm going to try to keep you engaged as much as I can. But we've already heard that practice expense doesn't get maybe as much love as some of the other areas of the fee schedule, and you might be tempted to conclude based on that that is because it's not important or

maybe there's no issues with it. So I'll address each of those and hopefully disabuse you of those conclusions.

So, first of all, in terms of the importance of practice expense, it's serious money, it's almost half of the fee schedule payments, aver $30 billion a year. We've heard already that's just Medicare Part B. It spreads throughout the health system in the United States, so really we're talking about something that's a significant driver of everything from specialty choice to investments in facilities and service lines. So it's important to get this right. Now, I think the way that we do this, it's a very complicated formula that I think -- I'm convinced there's maybe only a handful of people anywhere that really understand exactly how it's done. Most of those people are probably here. But I'll just kind of quickly go through how this works, just so we're all on the same page.

So practice expense is the cost of maintaining a medical practice. So what we do is we count some of the direct costs that can be more easily allocated directly to specific services. So we've got some equipment, we've got some supplies, and then we have some other things that go into the practice that need to be allocated down, and those are electricity, internet, rent, administration, those types of things. Another type of direct cost would be your clinical labor, that's non physician clinical labor. So we count that as well. Here we see a very different type of physician office, but we use the same type of method. So we count -- here we've got some equipment, it's the chairs, we have some supplies, it's the Kleenex (laughter), and then we still allocate down the electricity -- you're laughing, but this is really how it works.

So let me give you a couple now concrete examples from the fee schedule. I copied these directly out of the fee schedule public use files. So, first, we'll start with colonoscopy, a common procedure. We estimate our clinical labor time down to the minute, so we know it takes precisely 83 minutes of intra service time for a colonoscopy, for nursing. We count all of our equipment. We've got the video scope, the suction machine, the endoscope disinfector, and we have an estimate for the useful life for these, the purchase price, the time it's used, again down to the minute, and we can use those to calculate the cost. And then, finally, the supplies, very detailed list again, ranging everywhere from the distilled water to the lubricating jelly, the shoe covers, the mask, the gown, the drape, the cap, et cetera. And there are estimates like this for, again, thousands of procedures in the fee schedule. You can look it

all up.

Back to the psychoanalysis. So there's a different type of counselor -- these are again real values, you have no labor. Under equipment we actually do have the couch and two chairs and we do have the tissues -- they specify Kleenex -- and it's .05 boxes that needed per visit. So a very precise estimate and some good conversation validity actually between the Sopranos and the fee schedule. (Laughter) So it's possible one has covered the other, copying the other. The direct cost data come from expert panels. Currently this is Practice Expense Subcommittee of the RUC. They do some data collection from specialists out in the field, they use a reference procedure in order to value new procedures and update procedures. There's been various incarnations over the years, but that is the method we use.

For the indirect costs we have data from a survey, the PPIS, which was sponsored by the AMA. It's about 10 years old, it uses a sample of self-employed practitioners and some non-physicians. There's no plans to update that. And CMS actually calculates this for a fairly long list of different types of specialties. They're not all covered in the PPIS, so there's some cross referencing that happens.

Finally, there are two sets of practice expense RVUs that are calculated, there is your facility based and your non facility based. And there's different costs there. We heard a little bit earlier about the site of service differential, and so what I want to focus you on here is just the recognition that physicians are compensated even when practicing in a facility for their practice expense of maintaining their practice separately outside the facility. So if you're doing a procedure in a hospital setting there's an assumption that you still have staff and an office and rent all those types of things, billing, et cetera, that are in an office. So for colonoscopy that's a difference of 6.7 PE RVUs if you perform it in a non-facility setting versus 1.94 to cover those office costs if you're actually over in the facility.

The valuation approach is too complicated to go through here, but let me just point out a few of the salient points here. One is that it works on allocation of direct pools. So although we count all those precise things that's just to allocate the total pool. It's all budget neutral and it produces only relative value. So we're only interested in not the cost of Kleenex per se, just how much Kleenex costs versus the endoscope. A second point here is that there are specialty specific adjustments that go into this, so we recognize the fact that different types of specialties have different costs of running a practice,

they have different types of practices. And then, finally, the indirect allocation -- Joe I think mentioned that this is pretty much arbitrary, which is true -- but the way that's done here is on the basis of your direct PE. So if you have more equipment and supplies, et cetera, you have more practice expense, more indirect cost. And if you have more work you also have more practice expense. So it's not just the time it's also the intensity. If you're doing a more intense service that probably requires more electricity and rent and so forth.

Okay, so onto some of the issues and possible policy responses. So these are just, at a very high level, a few categories of different types of issues we're facing. One is the accuracy of these inputs, both direct and indirect costs, and also how do we keep those up to date. A second is false precision, which I think came up this morning. Do we really believe that we can estimate the cost of these things down to the individual minute or the individual unit to the 100th of a box of Kleenex? The system is engineered for things that are easily counted. So how do we really believe in those estimates, what could we do about that? Third thing is the facility/non facility site of service differential. Practice arrangements are changing and are physicians really maintaining their office still. And the final thing is that there are other relative valuations in Medicare for different services. Those exist through the OPPS, which is a payment system for hospital patient departments and also ASCs (phonetic). And isn't it a little bit problematic that even within Medicare we have different relative valuations for the same services, never mind the absolute different between site of services.

So I'll go through each of these three basic categories of policy responses, starting with could we update the inputs that go into this. So the PPIS is 10 years old, it's not representative of current practices, isn't it time to update this? There are other existing surveys out there that collect some information about what it costs to run a physician practice. And there was a nice article in *Health Affairs* about a year ago that went through this and concluded that although you could draw some information from those surveys it's not going to replace the PPIS. We can't just swamp something in. So we might be able to draw some information from those as a patch. We could also go out and field another survey. It's not the easiest type of survey to do, especially if you want specialty specific data. You need a pretty large sample size within each specialty, you're collecting a lot of detailed data on costs. Physicians don't have a lot of time to answer surveys like that. And we're trying to do this right now so I can speak from

personal experience, it is possible. So it's difficult but it's not impossible. So we could do it.

This morning I think Mark Miller also mentioned the recommendation of hey, maybe CMS should just pay some practices to just be monitored for their work and if they do that you might as well do some cost data collection for practice expense as well. You've got retail stores that are out there that are tracking everywhere that every shopper goes in the store, where their eyes go. Maybe there's some type of technology we could put in some physician practices if we're really thinking out there about a way to collect costs data in a way that's continually updated. I don't know if physicians would be crazy about that either, but.

A second category would be to adjust this facility adjustment. So it's probably time to collect more information about what practice arrangements look like. So recognizing that it's not as simple as physician has an office and every once in a while goes over to the hospital but still is maintaining the separate office. Given the fact that we're seeing more and more hospital acquired or hospital owned practices, we're seeing more and more physicians that almost exclusively practice in a facility setting, so what is the true cost again of just maintaining a separate office for facility based services.

And the final category is the most important. So this would be is there a way that we can reengineer and simplify this valuation approach. And this starts to get into some of the broader questions that we've already been discussing today about do we want to keep on investing in this fee schedule as is currently structured or do we want to consider a restructuring. So there's everything we could do here, from some pretty simple tweaks to more complete reimagining of what we could do. So on example of a tweak, in the propose rule for 2018 for the fee schedule there was a proposal to address the fact that there's some services at very low direct cost. So think about that psychotherapy service, the direct cost for there is the Kleenex and the chairs and we're using that as a basis for allocating all of the indirect costs as well. And what that leads to is a $.72 cost difference estimate between the facility and non-facility settings. So we're saying for a physician to provide that service in a non-facility setting only costs him $.72 more than if they were in a facility setting which is also getting paid. So CMS said that's probably not right. So for this we're going to set a floor, we propose a floor that's based on the most common type of E & M service.

So that would be one simple type. One step further would be something that Katie and Steve simulated a few years ago in a report for ASPY (phonetic). So this would be looking at the indirect allocator, is there a better way to allocate it. So I mentioned before it's now done on work and direct PE and it has a specialty specific adjustment. Well, perhaps instead of work, which factors in intensity, maybe the better unit would be time. And maybe it doesn't make sense to have the specialty specific factors adjusted. We've been paying certain specialties more for the cost of maintaining an expensive practice. They turn around and invest that money in the practice which makes it more expensive. So there's some endogeneity that perhaps we should think about removing.

So they looked at a simulation of what it would look like if we valued practice expense in the fee schedule taking those pieces out or changing those pieces, and that result was generally you'd increase payment to most primary care specialties by about six percent and then there would be a corresponding decrease to most specialists, because it's all a zero sum game, so you increase some and it has to come out of somewhere else.

And then, finally, maybe we could do something completely different, and the sky is the limit here. But one idea would be could we use some of this information from the outpatient perspective payment system. So there is a valuation methodology that is used in OPPS to get relative values for services, it is based on hospital cost to counting through cost reports and analysis of claims, and it leads to different relative valuations for the same services. So could we either use that to identify mis valued codes or could we use that to set some bound around some of the relative valuations around services and get to some conversions and methodology, at least within different Medicare payment systems.

So, in summary, although practice expense hasn't gotten a lot of love I don't think that's because there's not some improvements that we could make there and I think it's extremely important that we do that. We just need to decide whether we want to focus on investing in improving the current system or if we want to perhaps start with a reengineered approach and then think about new ways to measure the cost.

So, thank you for bearing with me through that. (Applause)

MS. MERRELL: So, first of all, Peter wins the prize for persevering under adverse conditions I say. (Laughter) And I was actually really impressed.

So right now I want to -- before we open it up -- there's several steps before you guys get to ask questions. And I know you're dying to ask about the Kleenex prices. But first I wanted to see if Antoine has anything he wants to add just from a sort of process or technical nature as you guys grapple with similar issues in Canada, or is it really different, or does this sound kind of familiar or something else?

MR. GROUIX: It definitely sounds familiar. That's one thing. We've been trying to figure out what's the cost of these Kleenex (laughter) and other furnitures outside hospital actually. And what we came up with, maybe 20-25 -- I think it's more than 25 years ago, is a percentage of physician's earnings. So when you are a physician and you're working in a hospital let's pretend your salary is $100,000, for instance. When you're out of hospital that salary will be increased by 33 percent, more or less. So you're going to earn $133,000. The thing is that was the earning for physicians 30 years ago. So as the earnings came up to what we have now on average for overall specialties, close to $400,000 -- is it $350,000, $100,000, the percentage of these Kleenex didn't rise on the same trend. So Kleenex are nowadays 6 times what they cost 20 years ago. They are more expensive, but they're not 6 times. So what we're seeing right now is doctors getting a very, very strong appeal for out of hospital practices because of this percentage that now they can put in their pockets since there has been no evaluation of that cost, exactly what you were describing. There has been nothing to evaluate that for the last 30 years. So we have no clue and hence we are just paying $100 a box of Kleenex more or less.

MS. MERRELL: So I also now want to give everyone else sitting up here a chance to either add something they wish they had said or ask each other something that came up as they were listening. But maybe not. No. We're going to ask Peter about his mad skills to talk through that later.

So I get to ask questions first and then you guys get to. I wanted to first ask sort of we hear -- there is a lot of grumpiness about the fee schedule I thought this morning and I wanted to sort of reflect back, as someone who has spent time on Paul's notion of as a scientific there's data, we do a lot of math, as you guys have heard. Are there some other features that this whole architecture has given us that maybe supports things that aren't these problems? Like some of these other payment policy things that Bob mentioned. We had the bonus payment for primary care for five years or four years or other things like that. So does the architecture support strategies for reaching other policy goals even if some

of these mechanical problems continue to vex us? And maybe they have to vex us no matter what. Even if they were better they may still be vexing us. So are there some strengths to this architecture that these technical problems maybe don't acknowledge or let us reflect on?

Joe?

MR. NEWHOUSE: Compared to what other architecture?

MS. MERRELL: You tell me.

MR. NEWHOUSE: Well, as I said in concluding, if I think a mixed system with some fee-for-service component and some per member per month component would be a better system, but you could incorporate what you are talking about in that kind of system as well.

MS. MERRELL: So in your mix model -- but I still need a fee-for-service system, so do you think the fee schedule serves your approach okay or would you throw it out and do something different? In your mix model.

MR. NEWHOUSE: You mean the current fee schedule?

MS. MERRELL: Sure.

MR. NEWHOUSE: I would throw out allocating all the indirect costs that Peter started to talk about and then costs that were directly associated with a specific service. So the gel for the colonoscopy I would allocate to the colonoscopy.

MS. MERRELL: So you would do the direct -- you would keep working directs but then take away the indirect allocation --

MR. NEWHOUSE: Correct.

MS. MERRELL: -- and say that the capitated payments (inaudible).

MR. NEWHOUSE: I mean there are still the issues that were raised this morning about what is the service and how much bundling is in the service. That's a big unopened issue.

MS. MERRELL: Fair enough. Does anybody else have?

MR. HUSSEY: So I'll make a comment that relates back to something Joe said and that came up earlier about the urban-rural issue and the geographic adjustments. So one of the reasons that I got into the Medicare fee schedule at the beginning of this process is that I was involved in the development of the original geographic adjustment factors to adjust fees across the payment localities

and it was very clear that while I was taking a nice labor economist compensatory wage differential approach to thinking about this, there might have been some people in congress that were thinking about this is an opportunity to raise fees in rural areas and lower the in urban areas, or at least compress the difference. So there's no question that the architecture related to the geographic adjustment factors gave people that policy lever. You know, it went from the fact that we thought there was X amount of variation to the fact that it was implemented as one-quarter of that variation in the adjustment process, and then over the years there have been floors put on the work RVUs, floors put on practice expenses, and all of those things allow the people making the political decisions to shift dollars around geographic areas. So that's a policy objective. Whether you think it's a good one or a bad one, it's certainly the architecture allows people to do that.

MR. ZUCKERMAN: I would say it's an interesting question. I mean I think we still need to understand the costs of providing these services. Maybe I'm too locked into the current way of thinking, but I think the underlying idea of a resource based payment is a good one and if we're going to have this administered pricing system, or some variant of it, I can't see away around collecting data on costs to do that. If the unit of payment is partly capitation we need something that's at the capitation rate, unless we're going to get some kind of other way of setting that price. I think it's important to understand the costs. Listening from the other countries it seems like maybe there's some similar problems, maybe in different directions. So in your case the costs -- in our case we're pushing people toward hospital owned practices and in your case people are staying out of the hospital. But it's the same fundamental dynamic that's pushing it.

The things I wonder about, you know, I don't have a good way of doing this, but is there a way to get more of a market signal to set some of the prices? So for at least some types of thing is there some kind of competitive bidding that we can do or get a price signal? Or is there something similar to what we've heard about, say in France, where we could set up at least a negotiating dynamic that gets at prices better than the way that the RUC is doing it. It seems like it was intended for the RUC to do that but hasn't ended up working that way.

MS. MERRELL: So, Joe, can you address the question about how you want to set your capitation rates for your partial capitation?

MR. NEWHOUSE: I would do basically a risk adjusted system. What percentage should be in the capitation and what percentage should be in the fee I think is going to require some experimentation. There's also the administrative cost of doing a fee system, although if I'm running a medical organization I probably want to know what's going on inside the organization, so I probably need to collect data on exactly what my physicians are doing anyway. But I don't have a fixed notion of how it should be divided between the capitation and the fee.

MS. MERRELL: But how do you get the -- regardless of --

MR. NEWHOUSE: I'm with Peter, I would have the fee ideally right around marginal costs.

MS. MERRELL: Right. But the capitated part, how do you get the capitated rate?

MR. NEWHOUSE: Well, that -- it's going to depend upon how much I want to pay in part. I'm not wedded to a "scientific way" of getting that.

MS. MERRELL: So Peter actually sort of guessed at one of my questions that listening to everybody this morning -- and as a math guy this is tough to say -- but one of the things I kind of started wondering this morning, and especially some of the comments from Barbara Levy about the RUC, was at the end of the day, in all of these countries and in our own fee schedule, is this inevitably sort of a big negotiation. And so maybe we're overly fixated on the notion that it's science. We've talked about false precision and too many decimal points and how many Kleenex, but at the end of the day maybe it is about a kind of complicated dance among a bunch of stakeholders who end up just sort of settling on -- seems to be okay. And then we have to worry about what are the signs that it's not okay and we haven't got the negotiation right.

So I'm wondering if you guys can kind of quickly do a thought experiment with me that you didn't know I was going to ask you about, is to kind of think about what you talked about today as sort of a set of negotiations, like just a mechanism for a bunch of negotiations. And is the issue more about who's involved and are we having the right -- is it the right game for that conversation versus do we have the number of Kleenex right? Does that kind of make sense, my question?

MR. HUSSEY: It makes sense conceptually. It's hard for me to figure out how that works in the U.S. in the terms of who's negotiating with whom.

MS. MERRELL: Well, I'm just positing that's what we're doing. I'm just positing that's really what we've got.

MR. HUSSEY: Who is "we" is the question.

MS. MERRELL: Everybody in the room.

MR. HUSSEY: Oh, everybody in the room?

MS. MERRELL: And my mom, but she didn't know. Like the whole system. Maybe what we really have is a big negotiation, right, and we do it through these different mechanisms and we do it through common periods and we do it at MedPAC and we do it through the RUC.

MR. HUSSEY: But my understanding of the foreign system is there's an umbrella physician organization that's negotiating as a unified entity, and that's what's hard for me to imagine in the U.S.

MS. MERRELL: Fair enough.

MR. ZUCKERMAN: So thinking about the mechanism that we do have in place in the U.S., so as I said, you know, if we get physician time is overstated but we think the relative work RVU seem reasonable, then we have intensity very wrong in the current fee schedule. The reverse is, you know, if time is overstated but you think the new time implies intensities that seem reasonable, then work RVUs are very different. And I guess as much as I've thought about this from a data standpoint, I don't think you're going to get around the fact that you're going to have to have some clinical judgment in here. I know there are many people in the room who are, you know, not fans of the RUC -- I'm probably included in that group -- but somehow, whether it's the physician associations in other countries or some sort of a physician advisory board, I personally would think that it would be better to have sort of an independent physician advisory board recruited by CMS. But somehow you're going to have to have this professional judgment in here. But I think the objective data shows you where the problems are. Do you believe that interpreting an MRI of the brain is as intense a service as partial removal of a colon? I mean those are the kind of questions that the empirical data raise.

MR. HUSSEY: I would just add that I think it would be -- first of all I agree with your take that it is ultimately -- it is kind of a political negotiation now of some type and it's on the basis of some very technical hard to understand algorithms that go into valuing this stuff. So I feel like if we could do what

we were talking about this morning and get it down to whatever the right number of codes is, it gets a little easier hopefully. At least if it's more transparent I think you could have a better negotiation. And the problem now, if you make a change, a certain type of change, I don't think anybody can really predict what the effect would be until you run the numbers and see and say that's politically unacceptable. And there must be a better way to run that negotiation or that process.

MS. MERRELL: And that's my last question before I open it up, which is stability. And one of the things -- I've been involved in a bunch of the CIMA MY models in different areas and one of the things that different specialty groups talk about is things that they view that the rates can change crazy year to year for certain services and they will happily buy into some kind of a more prospective fixed thing if it's more stable. And so one of the things I'm wondering about, you guys, is things that we want to fix in the short run versus maybe there's a better model, except for who knows, it's a bunch of experiments versus -- and I feel like I like all of that but I wonder how much turmoil and innovation the system takes before everyone just like explodes or something.

So I'm just trying to figure out how do we balance -- how do we learn, how do we innovate versus how do we undermine any sense of stability and buy into the endeavor broadly? Does that make sense?

MR. NEWHOUSE: I interpret this as part of a question about how society deals with technological change more broadly, whether it's robots or whether it's Chinese manufacturing firms, that goes way beyond medicine. Medicine is perhaps more difficult because there's been such a huge investment by the physician in human capital in terms of the length of training, learning a particular set of skills, particularly since we're so specialized. If something I'm doing, a GI person doing colonoscopies and the technology were to change to virtual colonoscopies I have a problem. And I think the stability you're talking about is actually a small part of the overall issue of stability. There's no easy answer to that problem. We clearly want better technology if it's better for patients. And, you know, we tolerate the kind of dislocations that it causes in general.

MS. MERRELL: All right. Questions? Her microphone works better than mine.

QUESTIONER: I have a question for --

MS. MERRELL: Can you identify yourself?

QUESTIONER: Oh, I'm (inaudible) from Office of the Actuary, CMS. I have a question for Mr. Newhouse. You mentioned three studies that studied the volume response from physicians to fee changes. And I think you had a bullet point on your slides that seemed to summarize your thought on this issue. Unfortunately I missed it, so I'm curious of your thought on that issue. And also, more importantly, based on the historical evidence of the volume response, I'm wondering what you would think about the volume response when physicians are moving into the MIPs and APMs, how they will respond to the bonuses and penalties in the new system.

MR. NEWHOUSE: I'm going to try to look at that last question. So the main point I wanted to get across with those set of studies is that fees do matter, or the level of fees matters to how patients are treated. And which sets up all of the other questions we've been talking about in terms of trying to get to the fee schedule or type of reimbursement system that we want. And then the subsidiary point was that both the theory is that the effect of a fee change can have a positive of negative effect or services supplied, and we see that in the studies. Two of them come out with a negative effect, increase in fees, decrease in services. One of them comes out with the opposite, increase in fees, increase in services.

And I don't know that a general statement can be made about the MIPS system. I certainly haven't tried to look at it.

MR. ZUCKERMAN: One thing I would say about the volume response, I think it's consistent with the studies that Joe referenced and some work that I've done also, is the idea that there's a uniform volume response for all services, which is something that I think has been assumed in various analyses, either at CVO or OECT (phonetic), is probably an oversimplification. That it's a complex system and the conditions for which -- in Joe's context the income effect or the substitution effect tend to dominate are going to vary across types of services. And I think that that's just analytically something important to keep in mind.

QUESTIONER: (Inaudible).

MS. MERRELL: Yes, you may, Bob.

SPEAKER: He's probably not going to like that we're using so much economic jargon.

QUESTIONER: No, that's not the problem. So is the conclusion that you cannot modify

fees --

SPEAKER: No.

QUESTIONER: -- to achieve -- okay. So my understanding about Japan is that they actively looked at fast growing services. And whereas in the U.S. it's a screen for deciding whether the resource costs might be wrong, in Japan they actually looked at MRIs, they dramatically reduced the fees over a number of years, did not see an adverse effect on volume -- volume went up, but not at the same rate, and consider that to have been a very successful implementation of a price change to achieve a policy objective of decreasing costs for unnecessary MRIs. Can we do something like that do you think in the U.S. in the RBRVS to add an explicit component of changing price to affect volume?

MS. MERRELL: Well, that's actually one of the categories called out on the potentially mis-valued services.

QUESTION: Yeah, but what we do is we say that those are services worth looking to see if the resource costs are right. What they're doing Japan --

MR. NEWHOUSE: (Off microphone) that if you reduce fees you'll reduce volume. And both of what we just said was you can't necessarily make that assumption.

QUESTIONER: So the question is -- so there's nothing you can do in that area or do you do it very carefully?

MR. NEWHOUSE: Well, no, you may just have to feel your way along.

QUESTIONER: I mean another example, which I don't know that you've looked at, but the natural experiment in the U.S. was the Deficit Reduction Act of 2005, which --

MR. NEWHOUSE: Well, that was the cancer chemo example. It came from --

QUESTIONER: Okay. But it also had an effect on imaging service and the GAO then looked and found that prices were reduced 12 percent, I believe, and volume kept going up but not at the same rate. It seemed to be a very good policy result. And years later volume is still going up, but at lower rates than they were going up. I think that's a success story.

And I guess my question to you is is that sort of a one off or is this something that could be considered as part of a reformed fee schedule more actively try to build in behavioral responses to fee changes as a way of establishing a fee schedule?

SPEAKER: Let Joe answer first, but I had an answer.

MR. NEWHOUSE: I agree with that. As I said, we've (off microphone).

SPEAKER: Yes. What I was going to say is that the services that were reduced in Japan and the high end imaging that was reduced here are distinguished because a lot of the expense producing those services, practice expense, so it doesn't run into the income and substitution effects, so they'd agreed that say a visit would.

QUESTIONER: To add to Bob's question, which is a question to all of you, but Bob as well since he's a physician. Would you wish to suggest that policy should be made only on the impact of a fee change on utilization without considering the question of whether it has anything to do with appropriate utilization in making health policy?

MR. NEWHOUSE: Certainly not, although reimbursement per se or the fee level per se is one tool for that purpose. (Off microphone 16:57:46 -).

MS. MERRELL: His microphone is not very friendly.

MR. NEWHOUSE: No. The short answer is I don't know about that, but there we do obviously have payments that are various quality incentives, which is where I think this question would go in a reimbursement scheme.

MS. MERRELL: Just on that point real quick, when the fee schedule was implemented in the early '90s and PPRC -- I was at PPRC and we introduced the practice expense methodology that's in effect now, and we introduced the notion of a site of service differential, and when we first started talking about it one of our commissioners who -- happily I don't remember who it was -- said well this is absurd because if you price things in both settings you're going to be saying you could do bypass surgery in your office. And I said, is that really what we're saying? Can't there be other factors that dictate whether what you do or not -- like just because we priced -- we actually didn't publish a price for (inaudible) in an office, just FYI, but even if we had it didn't mean someone had to do it, right. So this question has been there all the time, and that's kind of what I was alluding to earlier this morning about CMS can't tell doctors how to practice medicine. And it's tricky what that ends up looking like. And so it becomes a kind of a hard conversation about what's priced versus what should be done. And there are examples of things that are still priced that probably most clinicians looking at it would say they really still do that to people? Like

that's not a thing. Like they shouldn't do that anymore. And yet it's really hard to prune the Christmas tree. And so I think that's a tricky business about what like should be there versus the more benign neutral sort of hand behind it. Does that make sense?

QUESTIONER: So in geriatrics we have a saying that when you lose money on every case it's hard to make it up in volume. (Laughter) And the point of my saying that is to ask whether the behavioral responses to changes in fees might have to do not only with the direction of the change, but where that places the fee in relationship to the perceived work and costs of providing the service. And that may be a factor. I certainly think that would be a factor in determining that.

I do have one question. At the RUC and in the fee schedule in general, we try to -- and I'm talking specifically about physician work -- we try to evaluate the work for the typical patient. Well, what is the typical patient when you're talking about E & M codes that cover the whole universe and how can my patient, as a geriatrician, is an 82 year old with 4 chronic conditions and a dermatologist has a totally different typical patient? And this is a problem. And then another problem with it is I would argue that the cost problem in general is not necessarily related to the typical patient. It's related to the atypical patient who is the very high cost patient. And it seems to me for primary care doctors the more complex and difficult the patient is the poorer an economic prospect that patient is because it's going to take a lot of work and the typical patient payments don't compensate appropriately for that. So I wondered if you'd comment about the problem of the extremely high cost or complex patients and whether we should tweak the system to take more account to that.

MR. NEWHOUSE: Well, in the capitated Medicare advantage system we effectively do. The HCCs account for that. And so that fits nicely with my two-part pricing kind of notion.

SPEAKER: But I mean in terms of the notion of setting RVUs at the typical patient, I think the idea behind that is if you can define typical. And I know for certain services typical is harder to define than others. You're going to have some that are harder than typical, some that are easier than typical. How that's distributed for any given physician is very hard to determine. I think this issue though of the visit and the heterogeneity within the visit, I think this really comes down to something that I guess I would characterize -- and people may take exception with this -- as kind of one of the original sins of RBRVS, and that's that we have a single visit code that's used by all specialties. And it's hard for me to

conceptualize as a non-clinician that that visit is the same service for all specialties. It's not. But I think that this notion that a service is a service and a physician is a physician was applied broadly across all visits. People may take exception with this, but I think that the fact that you have some specialties, psychiatry, ophthalmology, that have their own visit codes, but for most specialties everyone is lumped together. And I think maybe you pointed out -- or someone pointed out -- this morning that you raise E & M payments and specialists benefit as much as primary care doctors.

So I do think that that's a problem with the heterogeneity of E & M codes, which is one of the reasons why we shrewdly in our study of time eliminated E & M codes, because we knew that it was going to be impossible to study.

MS. MERRELL: But part of that is the problem of prospective payment, no matter what, right? So the whole notion of prospective payment will set an average even if it's -- pretend we can do it right -- but any particular actor may not actually ever end up with like a distribution around that average that makes any sense.

SPEAKER: But the typical may not be the average, but regardless. No, but besides that. I'm just saying prospective payment, it has that sort -- so if you as a practice -- and I think about the early AIDS patients, and the few guys in New York and San Francisco who started treating the early AIDS patients, they didn't average out in a year, right? And so I think the prospective payment -- I'm always -- at some point -- it may be worse here because of this problem, but generically prospective payment will always have that kind of problem.

SPEAKER: And there are some like -- I think the surgical codes, there are like some severe, higher severity modifiers, but I'm not sure how wide -- what those payment --

MS. MERRELL: There's more microphones. Sorry.

QUESTIONER: You know, so I mean kind of the bottom line is if we're going to save the cognates we've got to find money somewhere. And so if we're going to achieve income parity, which is kind of the name of the game, if we're going to get a workforce that's going to do what we need it to do, the money's got to com either from Peter to Paul, which is going to be painful, or from PE, practice expense. So the question is how much can we wring out of practice expense? And I think the caveat here is that the people that have made the most from the PE fluff are really the device manufacturers and

the -- the people who make the Kleenex. Those are the guys that have figured out how to use the system to support a whole bunch of things that go into PE per se. So it's not so much physicians against physicians, there's a big issue there, but there's also the notion that others have come into the system, figure out how to work the system, and now we're at a crisis point because our workforce is starting to tank. And it's not just primary care, it's infectious disease, it's rheumatology. There's a lot of these sub specialties that are in big trouble. And we need an answer and we need it really fast. I mean we're talking within the next few years because it's going to take us forever to rebuild what we lose unless we get something done.

So the question to you on the panel is how much can we wring out of practice expense to shift into physician compensation?

MR. HUSSEY: I will take that first because you said practice expense, although it feels like a loaded question. (Laughter)

SPEAKER: Don't take it personally.

MR. HUSSEY: So it's a zero sum game, so you could take as much as you want out. And it just needs -- there's no wringing it out of some other pot. It is all budget neutral and it's coming from -- if you're increasing one service you're decreasing every other service.

QUESTIONER: How would you do that?

MR. HUSSEY: There's a number of ways to do it. I mean I would start with looking at ways to simplify so we're not counting as many things, to get away from the dynamic that you mentioned which is -- and which I also mentioned -- which I think it's currently engineered towards things that are easily counted. And so if you got manufacturers of things that are easily counted you can do that. I think if you were looking at broader categories of service you'd get probably to a reasonable level of precision and costs for setting rates without encouraging, okay, let's tack on as much additional counted things as possible to gain this counting system.

MS. MERRELL: Well, and to be honest, CMS did do that, has done that in an area. I can talk a little bit more about it if anybody cares, but raising the assumption about utilization rates on expensive radiology equipment, imaging equipment, that effectively reduces the unit cost, which is what gets thrown into Peter's machine. And that was a very specific effort at kind of taking away the

importance of these really big pieces of equipment. And you can imagine there were some people who weren't big fans, right. So there are examples of trying to do that like that.

QUESTIONER: Hi, Carl Poser (phonetic). I'm just wondering why the assumption is if you're going to wring a little bit of money out of the healthcare system it automatically would -- that would go to providers and not to consumers. And my question is about monopoly rents or excess rents over normal profit levels. Is there any of that in the government set prices for Medicare? How much? And is the government helping structurally advantaged profession make these excess payments. You know, because of structural features like being paid by a commence (phonetic), being paid by insurance companies where individuals don't suffer the full extent of their consumption, by restricting supply because they -- you know, of licensure requirements, because they have tremendous lobbying power, and other things, asymmetry of information. You can go on and on. There's probably some monopoly rent -- I mean $400,000 a year? If they got paid $350,000? Huh? (Laughter)

SPEAKER: That's about $100,000 U.S. (laughter).

MS. MERRELL: I'm not sure that we have a (inaudible) response to that. Do you want --

SPEAKER: That's more a comment than a question.

MS. MERRELL: Yeah, I think that's more of a comment than a question.

QUESTIONER: No, I asked about the rents.

MS. MERRELL: Well --

QUESTIONER: You're economists, you're supposed to know about this.

SPEAKER: Yeah, I think we agree.

MS. MERRELL: No, well -- and we understand your question pretty well and I think the fundamental question you're asking at the end of the day -- and it was mentioned in the international one -- was whether or not there should be salary targets, right, in some of these countries. We've talked about the (inaudible) explicit salary targets, whether they differ for GP versus specialists and all that, and that ultimately kind of underlying your question. And we seem to accept as a society a pretty big difference, and relatively high for everybody compared to other earners. And that's kind of a cosmic question I think beyond us today. But I think we all acknowledge your point and it's clearly embedded in the way this is set up.

QUESTIONER: (Inaudible).

MS. MERRELL: There's was another one over here. Victor, I think.

MR. NEWHOUSE: So while we're going to this, so the only thing I'll say is that, you know, what we're really dealing with is kind of the access issue. I mean you're saying if you pay physicians a little bit less would you get fewer physicians. And I think that that's kind of an empirical issue. I mean MedPAC's framework for thinking about -- their payment recommendation is always is monitoring access. And even like Alan's question before, it's like Medicaid pays less in a lot of states and fewer physicians participate in Medicaid. Now, there's options there but it does become a matter of access. But paying less, you just have to monitor that.

QUESTIONER: As I understand it, a lot of this panel RBRVS didn't do very much for E & M services, for reasons you explained, Steve. The same is true in France in my experience. The whole study that was done, nothing was done on EMS, but the French, as I explained all too quickly, did come up with a whole set of prices for different EMS -- evaluation and management categories -- as I think in Canada.

So my question is to Antoine. In France they arrived at these prices, believe it or not, not through science, not through technical studies, but through just negotiations, systematic negotiations, and, you know, out of the air. If I read to you the different prices for the different kinds of E & M services, I would like to see your reactions. But I couldn't give you any studies on which they were based. In Canada, can you describe how this is done, or in Quebec, specifically with respect to evaluation and management services?

MR. GROUIX: We're obviously a little bit like the French people -- probably something in the blood (laughter), but for Quebec at least. As for Ontario they're the very first who were able at some point to lower -- just like you were saying in the rear there -- to lower the salaries. They decided that the physicians' income was too high. And this really is -- it's moved not only by science, not only by studies, but really by public opinion. At some point people get angry at the idea that a physician, even though studies are costly -- and I'm not talking about Quebec, as I said, or Canada at large -- but even though studies are costly, even though the stress is high, mental efforts, physical efforts, the technical aspects of it, at some point too much is too much. In Quebec everybody agrees on the fact that earnings of

$400,000 a year for a specialist and $250,000 for a GP is already extremely high and we're going on a new negotiation round right now. And everybody is wondering are we really going to increase their income again or are we going to freeze that or going to change -- just scrap the whole thing and start all over again. How are we going to manage that, because it's not -- the population will not tolerate increases in these amounts that are already sky high.

MS. MERRELL: The last question.

QUESTIONER: I was listening to this panel, I was struck by a number of instances where the lack of dollars has very much limited the research and even the policies to deal with these issues. When Peter was mentioning we need a new study, it's been 10 years -- of practice expense -- I remembered 10 years ago how overdue that survey was. And I think it was motivated by the really bad data that was being collected by specialty societies to gain on the other specialty societies. But in the sense it becomes relevant to, you know, the whole approach of using science. You know, if funding is going to be so constrained maybe we even have to think about something that is akin to negotiation to address the, I think, really severe distortions we have now.

MS. MERRELL: I think we're going to call it down. We're at the hour here, unless there's one more quick question? No. I think we're going to call ourselves ahead of time here, which is great. And we'll reconvene in 15. Is that right?

Thanks, you guys. (Applause)

(Recess)

MR. GINSBURG: Well, if you can take your seats now. I'd like to introduce the final panel that's going to come up with the big answer to everything we've talking about today. Please take your seats. We've got a lot of people that have interesting things to say on this last panel.

While you are assembling, I'd like to introduce the panelists. You've gotten to know Bob Berenson pretty well, if you didn't know him before today, from this conference.

Gail Wilensky is a Senior Fellow at Project HOPE, and she was the Former Administrator of the Health Care Financing Administration during the time when the Fee Schedule was implemented.

And we have Jonathan Blum, who is the Executive Vice President, Medical Affairs, at CareFirst BlueCross BlueShield, which is the plan that covers this area, and he's the Former Principal

Deputy Administrator at CMS, and also a Veteran of the Senate Finance Committee Staff.

Karen Fisher is the Chief Public Policy Officer at the Association of Medical Colleges, and she used to be Senior Health Counsel at the Senate Finance Committee.

And finally, Eric Schneider who, those who've been with us all day met early this morning, the Senior Vice President for Policy and Research at The Commonwealth Fund.

And we are going to run this panel in this order of people: Bob Berenson and Gail Wilensky have very well-known positions on this perspective of, you know, to what degree of resources, investments, capital, political capital, to put into revamping the Fee Schedule, versus alternative approaches? So they are going to present their thinking on it. And then the other three panelists will give their own thoughts, which I haven't debriefed them on yet.

MR. BERENSON: So, it's nice to be back up here again. Victor stepped out of the room. He accused me earlier of setting up a false dichotomy between fixing the fee schedule and proceeding with alternative payment models. As you're going to see, that's not my position; that actually is HHS's position.

As you remember, from a couple of years ago the Secretary presented a chart in which there were four categories of payments, and basically category one was fee-for-service which was labeled as no relationship to value. There's Victor. I was just talking about, I actually don't think there's a dichotomy between working on fee schedules and working on an alternative payment models, and I'm going to explain why in my presentation. I was being maybe a -- Well, in any case.

So HHS had that categorization. Category one is fee-for-service which has no relationship to value; category two, you add some quality measures and you're now on the value trajectory; and then three and four winds up with population-based payment with risk bearing.

So if you could open up my slides for me. There it is. My argument, in fact, is that fee schedules can provide more or less value themselves, it is not right that value comes only from performance measurement and financial risk bearing. There is no question that there are some inherent incentives with fee schedule base payment.

If you want to really get the indictment, you would see you would see a quote by George Bernard Shaw, in the Doctors Dilemma from over a century ago, which said that: because bakers can --

of course we've learned that you can pay bakers to make bread for you, we should give a surgeon money for taking off your leg and nothing for keeping it on. In his case he said: it makes me despair for a political economy, or something like that.

But it is fundamentally a problem with fee schedules. You are rewarded for doing stuff, some of which is unnecessary, and not rewarded for not doing stuff. And as Joe was talking, and the previous panel was talking, you do have an issue of trying to pay for the marginal cost rather than the average cost. And so I'm not necessarily saying that fee schedules are perfect, or the right way, ultimately, to pay, but my point here is that you can get a lot more value out of fee schedules than we have been achieving, and I have to sub-bullets to make the point.

I think it probably is a good thing that CMS is now identifying particular care coordination type activities that can be codified. And I actually wrote a piece about 15 years ago on the whole range of activities we want physicians to be doing, lots more communication with patients, with other doctors, et cetera, that involves lots of phone calls, lots of emails, lots of stuff that you can't pay on a fee-for-service, fee-schedule basis.

The transaction costs are greater than the value of the service, you've got moral hazard problems, by that I mean patients sitting at home drinking coffee, doctors sitting in their office drinking coffee, and every time they send an email back and forth somebody is going to be paying for it. That doesn't make a lot of sense to me. And you've got potential for abuse, program integrity issues.

So, I don't think everything can be accomplished with a fee schedule, and in fact consistent with Joe's recommendation, one of the payment models that I find most attractive that CMS is proposing, or CMMI is testing is called CPC+, Comprehensive Primary Plus. Then track 2 actually reduces the fee schedule, the amounts of fees in the fee schedule introduces, they don't use the term capitation, I think it's a care management fee, or something like that, but it's a PMPM.

And it is the kind of hybrid model that tries, I think, to balance incentives. But having said that there are things you can do with coding, too, if you can have a code that can be crisply defined, that it's got significant value that you can control the potential for abuse, gaming, I think that's a good idea, and CMS has been, over the last few years. And I think Jon may have been responsible for getting all of this started when you were at CMS, you can you can clarify that for us. I think that's great that they've

been doing that.

And then the second thing is more basic: how physicians spend their time and what services they provide or order affects value as surely as measuring and rewarding or penalizing a handful of quality measures. If physicians are paying a lot for recommending procedures, and then performing procedures, and very little for spending time with patients they will -- I'm not giving you anything new, this has been talked about on a number of the panels, so the relative fees matter.

And I don't think in that area CMS has had it right. I think that we are continually overpaying for mostly minor procedures, for major procedures we have this problem of too many visits are being put into the global fee, for minor procedures, the time it takes is far less than the assumption that's in the fee schedule, and I think the biggest area which our empirical research confirmed, was that test interpretations to some somewhat imaging but other kinds of tests like echocardiograms, electrocardiograms, other kinds of test interpretations, I think are the category that is most overvalued.

So we get lots of those services and spend a lot of money on those. And so I think we can get more value out of a fee schedule. But there's another set of reasons why I think we need to be paying a lot of attention to the fee schedule while we are also trying to support alternative payment models.

On the PTAC, and Grace was mentioning earlier her experience; for those who don't know, the PTAC is the physician -- let me see if I can get this right -- Physician Payment-Focused Technical Advisory Committee, right, or something like that.

SPEAKER: Physician-Focused.

MR. BERENSON: Physician-Focused Payment Technical Advisory Committee. There's 11 of us. This was set up under macro, there's 11 of us, and neither Grace nor I are speaking on behalf of PTAC, but we have impressions having served on PTAC now for almost two years. And as she mentioned there are some very good innovative approaches to delivery changes that physicians, many of whom are specialists, are proposing. But when -- I don't want to over generalize -- a few of them clearly the solution is, let's create a code, it's not a payment model, it is a code, you want a code for something.

There are issues in creating codes, but I'm just saying that not everything needs to be solved with a payment model. APMs are not easy. We are now on about the eighth year of -- seventh,

eighth year of CMMI actively pursuing demonstrations. We do not have any consensus, as far as I can tell, as to what direction we should be going with alternative payment models. We have strong advocates for episodes, we have other advocates for ACOs with shared savings ultimately going to significant risk bearing, but I don't think we are close.

So, fee-for-service is going to be here by default for a lot of the health care system. And in the discussions from this morning I guess I would say a lot of what are being proposed are aspirationally correct, but we have as Alan, I think, correctly pointed out, a crisis in primary care right now. The Institute of Medicine issued a report a few years ago on the workforce for an aging population, we have no geriatricians for an aging population.

Virtually none who are actually practicing, they are mostly supervising, to the extent that there are any. And I think a fee schedule could be constructed to reward, more generously, the services that certain specialties perform, and that should be a legitimate basis for modifying the fee schedule. Now, right now, and as I emphasized this morning, that has to be done from statute, that's an unwieldy process.

I would suggest perhaps there should be some amount of the fee schedule spending that could be within the discretion of the Secretary to allocate into services that would achieve particular policy objectives, and that can be done while we are trying to get APMs right.

Current payment rates are used as integral parts of most APMs, so that if you have mis-valued RVUs and fees you would -- these would be extended to APMs. Some of the innovative proposals want to share savings, for example, by billings. Well, if billings overvalue the work of certain specialists compared to other specialists, you will maintain the disparities in rewards, et cetera.

So, to price APMs we are typically using fee schedule prices, DRG prices to come up with a composite rate for a bundle or an episode, et cetera. And so just to reiterate this point, I think the real, where we want to wind up it's probably hybrid payment models that attempt to neutralize financial incentives, not create strong financial incentives, balancing the incentives we are stinting with the incentives we are overproducing, and that's what's the second part of CPC+, the second track of CPC+, explicitly, I think is set up to try to do.

And then Bruce mentioned earlier that he thought I was the one who said you have to fix

the fee schedule in order to do away with it, this was the bullet that's relevant to that. I think I did say that. It is that a lot of reform, I think, needs to be based around the development of multi-specialty group practices willing to work in a team-based multidisciplinary environment taking a population-based risk for -- well, taking risk for a population of patients.

When you have disparities of two to three, to even more, to one specialty income, to family physician, general internal medicine, pediatrician income in the fee schedule, it is that much more difficult to establish a well-functioning multi-specialty group.

I think that, Alan, were you the one who said you're having trouble recruiting primary care physicians in your group? And if you have a cardiologist who can make $600,000 in fee-for-service, how are you going to get them to work for 400,000, or 350,000 in a multi-specialty group.

So, my argument is, by correcting some of those distortions in fee-for-service, not having everybody pay the same, but by reducing the disparities somewhat I think it supports the development of organizations that ultimately will be in a position to either manage episode-based payment, or where I would prefer a move towards capitated type payment.

So, that's my sort of argument for why we need to be why we need to consider the fee schedule part of the value-based payment movement. We should not have this assumption that fee-for-service fee schedules are just valueless, and just by adding some quality measures and taking some non-nominal risks, we suddenly have value.

And with that, I'm going to turn it over to Gail. (Applause)

MS. WILENSKY: As is frequently the case what is positioned as opposing views turns out to be somewhat more nuanced than that, and that's going to be the case here. In principle, having more accurate is better than having less accurate, so it was kind of hard to say, at a conceptual level, it would be undesirable to have a more accurate fee schedule. And it would certainly be helpful to go after the -- significantly decide how to define that, either overvalued or undervalued services.

The problem that I have is at what costs, how much bandwidth exists in the Agency and CMS or MedPAC, or your Physician Advisory Group? And even more to me is, as a standalone the concept, not so much of the fee schedule or fee fee-for-service, but the micro unit fee schedule that we have focused on is inherently against the focus and outcomes. The persistent focus on inputs and the

costs of a particular input as opposed to what you get for that, put you in an undesirable position in terms of trying to acknowledge that there frequently are, can, should be different ways of getting to a health outcome that you are trying to have.

The extreme case being getting paid for cutting off someone's leg as opposed to preventing the need for amputation, but it's a reminder that focusing on the inputs can lead you to places you just as soon not be. And for me, even an improved fee schedule, as long as it maintains its very micro-level focus, is not going to help us move forward in terms of trying to improve quality and outcomes.

I am struck by what seems to be increased agreement from some very unlikely quarters with regard to what you'd expect for agreement, and how urgently we need to reduce the number of outcome metrics and quality metrics that we are using to get greater consistency by using a smaller set of outcome metrics that actually matter and trying to get them in broader use by different payers. And that is what troubles me about wanting to use up too much, either bandwidth or capital, political capital in particular, and improving the fee schedule.

So, to the extent we can figure out how to go after the most egregious over- and undervalued services, especially given that the fee schedule is the basis, at least now, hopefully not forever, but now for many of the alternative payment models that would improve it. But you are going to end up, still, at a micro-unit focus, and that makes it very difficult to promote the notion of accountability, of responsibility by the team providing health care for the patient.

To the extent we can promote more of a movement forward bundling and episode, you have an opportunity to cross different clinicians, and to look at the outcomes in a way that becomes very difficult when you have the micro-level fee schedule. And of course the fee schedule was constructed on the presumption that the payment should be the same regardless of who provides the service. I mean that was the underlying philosophy for the relative value scale, and there's almost, you know, meaning, irony I guess is the best word.

Now we are trying to figure out ways to get around that fundamental concept because we don't like the income distributions that are being produced, but it's hard to imagine a more challenging way to go change income distributions than to have a micro unit focused-fee schedule where the presumption is whoever provides that service ought to be paid the same for providing the service,

because it doesn't matter the quality and outcome.

It matters something about the input costs that are provided, is going to be able to effectuate the kind of redistribution of income that I've heard this already, Bob at the last panel also talked about. It is just contrary to the basic nature of what that goes.

So, I guess I would summarize my position of saying, if it doesn't cost too much, it doesn't deflect too much from where I think the focus really needs to be, which is, on trying to move more to an outcomes focus, and to an agreed-upon set of quality and efficiency metrics. And you are not exhausting all of your political capital which, you may have noticed, is actually in quite scarce supply right now. Then it's hard to say, no, it would be bad to have a more accurate fee schedule.

But I am worried about the bandwidth problem, it seems like we are struggling enough as it is with regard to trying to move to a more outcomes-focused activity and, as I frequently do, I will end by saying, it always takes me back to Joe Newhouse's partial capitation world where you acknowledge in interest and importance of having both a base payment, and having a variable payment. And you can decide how much it ought to be, and I tend to be less on the variable, and larger on the fixed.

But that strikes me as being inherently a better place to be moving than to focus on a very micro-level fee schedule. So, I tried to distinguish more recently in speaking, it's not the fee-for-service, per se, it's the service at the micro unit level which, I think, tends to get us in the most problem, because you could argue that episodes et cetera, are also fee-for-service, just a much bigger service unit that's involved. (Applause)

MR. GINSBURG: Okay. Now we'll hear from Jonathan Blum.

MR. BLUM: So, I'm going to kind of offer some thoughts, not from my former life at CMS, but my current life at CareFirst BlueCross. And seeing the world differently, similar issues, and similar concepts, and similar goals that I have today, that I did back at CMS, but a different access to information, different access to data and a different perspective. And I think given where I sit today, I'm probably more skeptical than I was previously, that we will see a world of new payment models other than fee-for-service.

And for a couple reasons, the first reason is when we look at our data within CareFirst we don't see our members staying within one hospital system, and I think when the policy community, at

least during my time at CMS, thought about how to think about how Medicare beneficiaries receive their care they tend to think about a ACOs, and accountable care organizations being the home for all the care that a given beneficiary sees.

What we see in our data is that members travel to different systems; different care delivery systems based upon their different conditions, and I think of the person that has multiple chronic conditions. They are not going to one place for all their care; they are going to maybe MedStar system for fantastic cardiac care, they are going to Johns Hopkins for fantastic other care, they have a primary care physician who is independent, that's really trying to be the quarterback to their complex needs.

We, in the private-payer world aren't very comfortable to tell people where to go for their care, and the Medicare Program, it's not very comfortable telling people where to go to receive their care. The foundation is that people get to choose where they want to go.

So that being said, thinking about payment models that lock in people to given delivery systems for all their care, all their conditions, that's not how people choose to receive their care. And so for that reason I'm very skeptical that we'll ever see clinical bundles or other models that really capitate the care to one given system one given ACO, or one given hospital system,.

The second insight to that I had coming into CareFirst, that I didn't necessarily have during my time at CMS, is that the differences that we see in care delivered for a given episode of care, in the CMS context, you see data, you see wide variation, and cost and care, the same geographic area. And you come to the conclusion, well that doesn't make sense, that's not rational.

And I think in the private sector, at least from my vantage point right now, you can really see the individual care journeys that somebody takes, and the reason why they chose SNF care versus homecare isn't because the system was producing an irrational result, it was that the person didn't have somebody at home to let the home health Agency come in the door. Therefore, the physician team felt that SNF care was the best, not for the best clinical outcome but for the best social outcome.

And so when you really dig into the patterns of differences in care for a given episode, hip surgery, knee surgery, a given procedure, you can look at population-level data and begin to see patterns that just don't make conceptual sense. And therefore you conclude: well, let's go to bundles to really change that incentive, to change that variation. But when you really dig in to why the physician thought

that SNF care, or this hospital versus that hospital, or this physician versus that physician was the best for the patient, there are social circumstances, there are risk-adjustment processes don't control very well for.

Now, given just those two reasons, people don't choose one hospital system, one ACO for all their care, when you really dig into the differences in care and pattern, it leads you to conclude that whatever payment system that we get to in the future, be it at full capitation through competing private plans, through APMs, they are going to be based upon the fee-for-service chassis.

And every model that comes to us that's proposed by a given physician or organization, really is a shared-savings concept, back in savings after you calculate the savings. So I don't personally believe we are ever going to get to a world of capitated alternative payment models. We'll get into risk sharing, and that's important, and that's a worthy goal, but we are still always going to rely on the fee-for-service payment systems as a chassis, as the infrastructure, and the fail-safe of payments to systems when people don't necessarily follow care patterns that are rational, but make perfect clinical sense when you really dig into the circumstance and the care decisions, and the fact that people don't lock themselves into one given system.

My family chooses to receive care from three different systems here in this area, they are all wonderful systems, but we would never agree to have all of our care provided by one system, nor can one system provide all of the care that my family needs. And the policy community, when it talks about bundles, and clinical bundles, and procedural bundles, I think it doesn't always take into account some of the very human things that happen, and the very real clinical decisions that happen that aren't always apparent when you look at national data.

And for that reason I am more confident than I was during my time at CMS that the fee-for-service structures will stay in place, we'll rely on them, and we have to find the resources, we have to find the staff, the money, the contract dollars to make sure that we are paying accurately, because I will predict in 10 years from now that the fee-for-service system will still be in place 20 years from now, 30 years from now, unless we start being comfortable locking people into one system and care, and unless we start taking away the real clinical human judgment that goes into deciding when a patient needs SNF care, versus home care, versus rehab care, when it's not just the clinical need, but it's the clinical and the social circumstance that drive those decisions.

So with that, I'll turn to my colleague, Karen. (Applause)

MR. GINSBURG: Thank you, Jonathan.

MS. FISHER: Okay. Great. Well, I think Jon was pretty explicit about your views on the fee schedule, and where that's going. And, you know, we could probably spend the whole panel listening to Jon because of his experience where he is currently, and plus his rich experience when he was Head of CMS, where he you really did take on the fee schedule and looked at mis-valued codes, and the RAC, and what was the valuation of that issue.

To the point about, that sometimes you have to look beyond the numbers and see what people's -- individual's decisions are and that there are things beyond just looking at the financial incentives. I think we are seeing that more recently even with socioeconomic status and those indicators, and how that affects the care that's given to people, and to individuals, and I think we are going see that start to play a role involved with many of these things.

I'm just going to do a sort of a smattering based on what I've heard before. I would say, if we look at the current fee schedule, you know, there have been, and it's been mentioned before about whether you do a primary care add-on to sort of help (inaudible) yourself the primary care payments. The complex code, and the care coordination codes, I think have been valuable, and I think after a couple of years of, you know, sort of stymied growth, till people were learning what you had to do to get those codes, it seems like they are making progress; how the palliative care codes that are being offered.

So there are tweaks that can be added in that front but, you know, it is beyond even the physician fee schedule, and I just came this morning from a discussion about workforce, and there was a lot of talk about, you know, other types of providers beyond physicians. And when we look at it and we say, I don't know who decided it, but it was 85 percent of the physician fee schedule that we would pay nurse practitioners and physicians' assistants.

And what role do they play in the health care system, and what is the valuation of the services they play, and you base that off of the physician service. I would also say that when Gail talks about what is the bandwidth, and if you tackle the fee schedule writ large, I do agree that you really have to make a decision about, do we think the fee schedule will be that chassis for APMs going forward in the future. Because when I was on the Hill and physician payment was in my portfolio, I was always a little

bit disappointed because so many meetings with specialty societies were about individual codes and what the valuation was for an individual code.

And I thought: boy, it would be great, there's really smart people here in this room, if we could have a broader discussion based on your on-the-ground experience about the health care delivery system, and how do you think it can be changed. But that code was so critical to them and what the payment was for that code. And if you start to go in and looking at that, I think what it would evolve into again would be this food fight about looking at individual codes on that front.

And on that, we've seen that a little bit with the mis-valued code initiative that I think was impairment. I think Jon started, and then Congress passed that said, look if we can't figure out mis-valued codes that people generally agree are overvalued there's going to be a reduction taken out of the entire fee schedule.

And my understanding, I think, now is that they are still not finding enough of those. And I think, I will tell you, I think the underlying thinking of that was that the physician community knew which codes were overvalued, and if you put it to say: you either tell us or everybody is going to take a hit, that people would come out and say, I'll tell you, those guys are overvalued, go look at them.

And it really didn't happen, I don't think. And maybe that's because the reduction wasn't enough, that someone said, I'll take a 0.5 percent reduction across the board because I don't want someone pointing the finger now to my codes in the in that arena. I also would say, as we look at APMs in alternative payment models, I do think when we look at the fee schedules, writ large, we do need to look at them in the context of the direction at least right now, where payers, and the policy community, and the federal government want providers to go; and that is to alternative payment models.

So that we seem to be encouraging people to go to alternative payment models, but at the same time looking at individual payment systems, and so when we see growth there, and I think this might have been alluded to in the previous panel, when we see growth somewhere we say, oh, that's a problem. But maybe that's not a problem if you look at it in the context of an overall alternative payment model.

So that if you see some type of specialty, or something, growing and maybe it's because it's now being able to be done in the outpatient, and in the clinic setting, and you are avoiding an in-

patient hospitalization, that's a good thing if the concept is, those physicians are part of an ACO, or whatever, and they are looking at the overall payments and overall cost, and not looking at that individual silo.

And I feel a little bit, as I watch, I think policymakers and we are all sort of stuck into, we want to move people to APMs but we still keep going back to looking at a sector-specific analysis of everything. And I think as we move on we just need to think about that type of arena.

And then finally, Jon talked about bundles versus ACOs. I always thought of, spending a number of years in this space, that CMS' expertise maybe a MedPAC's was moving more into it the bundled space. You have individual units, the DRG system had evolved into bundles, you have now the outpatient system moving into consolidated APCs, and it just seemed like it was a natural transition that you'd move more into the bundled space, which would allow people to go to whatever health care system.

And then we sort of had ACOs sort of in the checker board sort of jump the track a little bit, and jump ahead of this and a lot of time has been spent on that. And I think it's still -- we are still not clear, and now we sort of have this mixture of bundles and ACOs, it's still unclear which direction it's going in, but I do think at some point someone needs to make a decision about that in terms of resources by CMS. Is bundles the way to go, or looking at systems and ACOs the way to go in the future? And I think that has yet to release shake out in that front.

And then I'll finally say, as someone who worked a little bit on MACRA, the one thing that really surprised me coming out of MACRA was the immense interest in physicians wanting to do APMs. I sort of thought people would stay in this MIPS -- I'm assuming everybody is familiar and knows the acronyms -- and doing the MIPS and see if they could get on the higher end of the median and make some money that way.

Particularly because the legislation threw in a bunch of money for the top quartile of people, and yet immediately the discussion went to APMs; and I don't know if that was because when people did the math the 5 percent bonus looked very valuable to them on that front, but just as an observation, I thought it was interesting how that discussion moved there, rather than saying, we are going to work within the fee schedule. So with that, I'll stop. (Applause)

MR. SCHNEIDER: Well, for those of you who are movie buffs, there's a character that

sometimes shows up at the beginning of a movie, and then when he shows up again you know it's getting close to the end of the movie. And since I was first early this morning, we are now at that part of the -- almost to the end of the movie.

So, I'm going to be a little provocative. First, I want to start by saying to Paul and Bob, thank you for organizing this wonderful day, it's been a tremendous discussion. I've learned a lot. I'm sure others have learned a lot from this discussion through a lot of perspectives expressed. And so, on behalf of the Commonwealth Fund we are grateful for what you've organized here.

I believe that the physician fee schedule will be with us for a while, as Bob does, but I also believe that Gail is on to something around the distraction, or potential distraction that it represents from other objectives that we have in the health care delivery system. And one question that occurs to me, having listened through the day, is whether the physician fee schedule prevents innovation by locking in outmoded models of clinical practice.

So, one of the things we are seeing in other industries, and this was alluded to in the previous panel, is tremendous innovation on the means -- the production processes for delivering goods and services, that has been happening at an accelerating pace over the last 20 to 30 years. And we also are on the precipice of a really powerful digital revolution that we are only beginning to grapple with, not just in the health care sector, but actually outside of the health care sector as well.

There are potential ways of delivering services that we can't even imagine today, that might be very real to us five years from now, I don't think anyone thought, to allude to my earlier metaphor, that we'd be carrying around high-powered computers in our pockets and our purses, ten years ago. I certainly didn't think we were going to be doing email in 1992 when I first got into this area.

So, I don't think we should underestimate the potential for innovation to really change the way the health care delivery system does its business. The physician fee schedule could be a powerful barrier to progress in that area, and so we should be looking hard at the ways in which it might be preventing that type of innovation.

So, what I wanted to think about, or what I ended up thinking about, with I'll say for four needs or wants that might guide activity in evolving the physician fee schedule, and also APMs, because I think it would be nice to align these two objectives, competing objectives. One about how to figure out

how to value the work of the system, and the other about how to value the health outcomes and other patient and public goods that it's supposed to produce.

So, the first is around delivery system innovation and it's really interesting to think about focusing on the high need high cost population which is a big focus of the Commonwealth Fund right now, and for other foundations that have joined us in focusing on that group, and thinking about whether the delivery models -- the innovate innovative delivery models that serve high-need, high-cost populations, how the fee schedule plays into the care for those populations.

One of the things I like to say is that we are in the business of trying to take high-need, high-cost patients, and turn them into high-need, low-cost patients, and if the fee schedule prevents us from making that sort of a transition, then we should highlight the areas in which that's happening and think about what that means for coding and valuation of services in that context.

The second sort of need or want, I guess, is what I would call a set of goals -- thinking about what our goals are for the APMs and/or the physician fee schedule. So, by its very nature the fee schedule is a policy statement, it sort of drives what's likely to happen, and we've heard that detailed very nicely today. But one possible way of reorienting this, is around not the work, not using the work and the description of the work as a way of defining the fee schedule, but thinking about the patient-oriented models that the APMs open up, which I think might be one of the reasons they are attractive to clinicians; because clinicians, many clinicians actually want to serve the needs of their patients more effectively.

So, patient-oriented APMs could be very powerful in aligning those incentives between patients and providers in thinking about how to produce savings, how to produce better outcomes could be powerful. We've talked about service goals as another important outcome, so better care coordination, we might actually reduce the fee schedule, create codes, in fact that's happening for better care coordination. But one can think about other goals, such as better education of patients, helping them achieve adherence, better communication, not just with the patient but also among team members.

I've been struck by the cognitive input discussion, or the discussion of -- the value of cognitive services, and in my experience there are good cognitive services, and badly done cognitive services. I think if we could get smarter about how to measure when cognitive work is being done well, we could make interesting progress on revaluing cognitive services. And what I mean by that is that we

are now on the verge of being able to do decision support -- digital decision support, use computing power to assess whether decisions that were made were actually for appropriate care, appropriate diagnosis, imaging, treatment.

And we don't have to necessarily rely on rigid protocols to achieve that end, we could actually do real-time research using a sort of digital capability to understand how decisions are being made in systems, and whether they are producing the services, and the outcomes that we are interested in. So this sounds a little futuristic I know, but again, I really do think we are on the precipice of something big in the digital revolution space, and we are seeing it in other sectors of the economy.

The third need or want that occurred to me was -- and it's funny, I haven't heard this at all today, which is the idea of patient or public input into the valuations of the PFS it's as if we've decided that's not even a possibility. There are some methods for gathering that sort of input from the public and from patients, it's not easy to do, but they could certainly define services -- you can figure out mechanisms for getting public input into the definition of value, the definition of what people are willing to spend on various types of services. Oregon did this a couple decades ago now, under John Kitzhaber; and I think there could be some more experimentation there on getting the public input to the nature of the physician fee schedule.

And then finally, I think it would be useful to try to plan a deliberate transition toward some future type of physician fee schedule that -- or improved resource coding evaluation, much the way the -- if any of you have been across the Tappan Zee Bridge over the Hudson River, there's actually, the old bridge is still there but there's a new bridge that they are building in parallel, and then once that one actually can hold traffic, they'll just demolish the old one.

And we tend to sort of think, well, we are just going to jump, but maybe we need to think about sort of how we would leverage a sort of parallel world where we are actually implementing APMs, and could use the APMs to learn about how we would structure a new type of physician fee schedule. And the two pieces I see is sort of potentially important infrastructure developments, and every week is infrastructure week now, by the way.

One is better developing the data systems to support this new vision of a physician fee schedule. So those are resource management systems that actually could align with what ACOs and

other organizations are trying to do, so that there would actually be a sort of standard around the resource management systems that could be widely used. And then the Quality Measurement investment, we've gone through Version 1.0 of Quality Measurement; everyone is kind of disappointed with that.

I think we could who could use another round of investment in really novel and creative ways of measuring quality, patient-reported outcome measures and patient reported experience measures, and how to incorporate those into the PFS.

And then last, I did wonder whether CMMI could use some of its authority to develop and test alternative coding and valuation systems in some local markets in parallel to what exists right now. And I know, again this is probably sounding futuristic, but it's the end of a long day, and so I'm trying to let my imagination loose, and get outside of the box. So, thank you for your attention. (Applause)

MR. GINSBURG: Before I go to the panelists for their other thoughts on what their colleagues have said. Eric, I want to ask you a specific follow-up question. It was a very interesting comment you made about innovation in medical care and whether a fee schedule is a hindrance to innovation. And I was thinking it would be the opposite.

I would think that bundled payment would be the biggest threat to innovation as far as its tendency to freeze in a particular approach to a particular type of patient; whereas, fee-for-service, you know, has a complete --- all the tools are there, and using them in different ways would be more seamless. I don't know if you have any thoughts.

MR. SCHNEIDER: Yes. I think one has to be very careful in the designing of bundles. I don't know whether fee-for-service actually does what you are describing, I think of the Medicare Advantage companies that are emerging to manage high-need and high-cost patients at home. So we've talked a lot about service setting today, and practice overhead costs. But what are those costs in the home?

So there are, I think fee-for-service doesn't really allow them -- to me, doesn't allow the maximum amount of experimentation. Bundles, I agree, would actually be more problematic if they lock in particular ways of using resources.

MR. GINSBURG: Let me turn to the panelists.

MS. WILENSKY: Thank you. I was surprised by Jon Blum's comment; that he thought the current fee-for-service would be better at taking account of the social circumstances of the patient than one which paid on a broader basis, like Medicare Advantage. It would seem the focus on an individual payment for units of service provided is exactly contrary. Now, it may be that I'm basing on what I observe.

I've been a Trustee for the United Mine Workers Health & Retirement Fund since 1993, and they are responsible for all of the health care to retirees and their dependents. And because they really are responsible for every conceivable medical event that may happen, they have been the most innovative in looking at, if somebody is falling repeatedly and ending up with a fracture. Sending someone in the home to see whether the steps can be built up, or there's a handrail that could be added.

And when people were showing up with the ambulances, because they were in remote places and didn't have transportation, they had more incentive to try to find alternative ways to get them delivered to their physicians without using the type of fee-for-service that we have now, especially in Medicare, which is a very siloed mentality of the physician, per se, and of little units of what the physician does, seems to me as antithetical as anything I could think of in terms of looking at the clinical and social circumstances of the patient. Even if the physician would like to, everything about the payment system works against that, so I was just -- that struck me as a very odd statement.

MR. BLUM: Just to clarify. I don't disagree that a payer environment can provide more flexibility and benefit or fringe benefit designs. I think just about every payer has an interest in providing that support at home or any other kind of care management that's going to avoid the care that's unnecessary. The point I was trying to make is that whether you are in a fully capitated Medicare, a private plan, you are an ACO, and that's on a shared-savings basis.

The challenge there; is you have to figure out how one health care system talks to the other, that patients don't get through care even within a capitation system, even within the best run capitated health plan, people are seeing multiple systems. And if you want to design payment that's tied to an episode of care procedure, tied to a clinical episode of care, within that capitation you still have to figure out how to pay providers that don't have a business relationship to each other.

Therefore, you are going to have to focus on how to pay accurately, how to pay precisely

for the individual service. And the notion that teams come together, I fully support that, and that's great, but that's not the reality of care that I see today, knowing that I've seen the Medicare Program experiences. Even the best ACOs that we think about, a lot of their care is going outside of their service area, and how do you think about paying providers that don't have the economic relationship back to the home base.

Therefore, the fee-for-service system will be that chassis, and those payments need to be accurate, and that's why I think we need to both develop the best delivery models, but that's independent of thinking about how to make sure that our fee schedules are accurate, they send the right price signals, and they provide the means for one health care system to communicate to the other, to ensure the beneficiary of the patient is getting the best possible care. And that's the point I'm trying to make.

MR. BERENSON: I just wanted to make a comment about picking up on something Eric mentioned, about getting consumer's/patient's sense of value, and fees, and to make the sort of unfortunate point is that by statute CMS has no authority to do that. You are supposed to pay for resource costs not -- so there's no -- the relative value to patients or to taxpayers of the relative value scale is not something they can do right now.

And the point -- I'm not saying that you thought they could, there's no discussion at the Congressional level, and maybe Karen could comment on this, about thinking of broader parameters first for the fee schedule. It was put in legislation in 1989, it was adopted in 1992, we are still doing resource costs, we are sort of fumbling around trying to get those right, and some other obvious opportunities to introduce some notions of changing or modifying fees to achieve policy objectives, to modify fees to generate desired behavior of physicians, which is a little tricky, as the previous panel talked about.

But it is being done in some places; it's just not part of the discussion. And to take it one step further, my understanding is that the staff at CM, the Center for Medicare, that is responsible for the fee schedule, is nine people. The staff at CMMI for alternative payment models is a couple hundred? A couple hundred, that's where the priorities are, and I guess I'm with Jon a little bit is, I'm not sure we are going to get there with that investment.

And in the meantime we are not really doing anything to sort of re-examine what that -- We now spend $90 billion basically on the Medicare physician fee schedule, the idea that nine people

would be at CMS to support that is sort of stupid, I guess is (laughter) -- I guess is what I would say.

It is not what any corporation would do to protect its investment of $90 billion. I mean just, and then I'll stop this tirade, PPRC had a whole Commission and what, 15 professionals who were worrying about every aspect of the fee schedule when it was operating. And now MedPAC has one-and-a-half or something like that, maybe two, who are great. It is I think sort of our commitment to the fee schedule has lagged, and so I'm not -- I guess, one of the points I'm making, is if we actually reframe the discussion so that people saw that improving the value of the fee schedule, which might include loosening up the statutory requirements a little bit, would contribute to value as much as our investment in developing performance measures or trying to get people to take risk.

MS. FISHER: You know, to say to Bob, first of all, I don't think there's a lot of discussion there. When I was there, there was a group that did came up that wanted to talk about the fee schedule but, you know, some of where the attention has gone, for right or wrong, has gone to cost measures for the alternative payment models, and sort of holding physicians accountable for the total cost of care.

So, you know, I don't know if it was PAM, or MACRA spent a large number of pages of legislative language talking about how you do attribution, and episode groupers, and who were going to -- So, it's almost like as much time is being spent as we used to do on fee schedules, and what's practiced expense versus work, or resource. We are now looking at trying to figure out how much to hold the physician accountable for the total cost of care, because for whatever reason we want to hold the physician accountable for the total cost care, MIPS has that provision in, it's been delayed.

But I think CMS is struggling with trying to figure out how to determine how much attribution to be placed on a physician, and when there are specialists, how much attribution should be placed on them for that total cost of care. And I'm not sure if that's the right place where they should be spending their time, but it's certainly out there that that's the direction a little bit, of where they are spending it, and that is a very complicated area in and of its own.

MR. GINSBURG: I have one question to ask the panel, you know, I think throughout this day a lot has come up about how little, not just political capital, but how few dollars we put into maintaining or improving the fee schedule. I guess it's not a surprise when a program has been in place for 25 years it doesn't generate that, which brings me to a question which is that, whether we just need,

you know, some small amount of change, or more radical change depending on your opinion.

How are we going to deal with this very under-resourced situation? You know, is there something that's going to capture the imagination of funders? I mean the people in Congress who fund this to give more resources? Or do we have to look very explicitly for steps to take that don't require much in the way of staffs and research contracts? I know if anyone has any thoughts.

MS. WILENSKY: I think there needs to be more of an agreement on where we want to go in terms of the organization delivery of health care before you can have any hope of getting that responded to. I mean as somebody who has spent time in almost all those places chairing PPRC, and then MedPAC, and the Agency, the sense has been that, although not particularly correct, that the world is increasingly moving away from this micro unit fee-for-service.

There never was a lot of inclination to put a lot of resources into its support, and there is, if anything, less of an inclination. And now because I think you correctly indicated, if you look at where people are putting their money where their mouth is, and distributing the resources between the Center for Medicare and CMMI, it's clear where the views are in terms of the relative values of future investments in it has not been improving the accuracy of the fee schedule, for whatever sets of reasons.

And I think that there would have to be a significantly different discussion than what we've had as to where we want to go. I do worry that focusing on the physician fee schedule will stifle future innovation, because it focuses on input costs, input costs that have existed in the past, and to me is by its nature as opposed to focusing on what you want done, what you want to get at the end of traditional ways of doing something.

But it's more that's my opinion. What we, I think, really need to get is more of an agreement on where do we think we are going if it is going to be fundamentally using the fee schedule as a basis for payment, then even though I think this would be a -- it will be a brawl in terms of who prevails, changing the relative values for individual procedures which has always been the case, or has been the case historically at least, that would be where we need to focus on, but it's hard to do it until we have some sense of: here's where we think we are going to, or where we want to go to in our next round of payment.

MR. BLUM: I think it's certainly true during my time at CMS that the Innovation Center

got more resource, it was a huge attraction from the CMS staff that worked more of the classic functions of the Agency to move over to the Innovation Center. And what I used to tell people who are thinking about, you know, deciding whether to stay in CM versus to take a new position within CMMI, you know, there's so much power in the individual decisions that are made during the fee schedule annual process and all the folks that visited the Karen, were all the folks that were ticked off at CMS because they had some code change, or some political decision to change the overall priorities for how we thought about at the time, the different spending levels.

And so I think we need to create, to Gail's point, the consensus where we want to go, there needs to be more investment, more infrastructure to how we think about the fee schedule, if we want to have a debate about whether to have the fee schedule based upon input cost, resource cost, or some other value notion, that's a great debate to have. And I think that, to me, is what's needed.

And while we are developing the delivery models, payment models, but I think build a consensus that, in my view, they are going to be built on the fee-for-service chassis, no matter how we design it, and then create the consensus excitement within the Agency too, for that development.

MR. GINSBURG: Any questions from the audience?

MR. POSER: Yes. My question goes to the --

MR. GINSBURG: Could you identify yourself, please?

MR. POSER: Carl Poser.

MR. GINSBURG: Carl, hi.

MR. POSER: I work on income inequality issues on One Project, and I'm a paid Policy Consultant to the long-term care industry, just by disclosure. So, I have a different kind of interest. On the issue of improving technology and productivity, and how to develop an incentive for that in a payment system, we have some precedent for that under the Affordable Care Act. There was productivity adjustments made to nursing homes when I worked in the industry and in the hospitals of about 1 percent a year I think.

So, basically the industry was being paid less to be more innovative and productive. And the research question is -- and I have another question -- do we know anything about how they absorbed that challenge? You know, how much in labor, how much in capital, and et cetera? I mean how did they

do that? That would give you some clue about a negative incentive. But when I hear here in terms of physicians, I hear: we are going to make them more productive by giving them more. So anyhow, that's a question about how you incentivize more productivity.

MR. GINSBURG: Okay. Let's see if there's a response. We'll hold your other question for later.

MR. BLUM: I'll take a first stab at it. The productivity reductions that were put into the statute, my understanding, was a clear goal to achieve scorable savings from the Medicare Program. And I think, in my own personal view, the pressure that was put by Congress and implemented by the Agency on downward pressure on hospitals and other types of providers, you know, created I think a different environment, created pressure to work together, created pressure to better coordinate care, created pressure to form ACOs.

And so, while it was a difficult change for the industry to absorb, at the same time I think it sparked a lot of the conversation that we are having today about the best payment model -- delivery model. So, that downward pressure I think really created much more acceptance for value-based purchasing or other kinds of quality-based frameworks.

But I think, Carl, your question is a good one. What happened? Did providers get more efficient or did they take away services? I don't think we've ever looked back at what happened, but at the same time I truly believe that that downward pressure that Congress put -- put in place by the Agency at the time, did create the conversation that we are having today. What is the future of payment? What is the future of delivery design? And without that downward pressure, I don't think we'd be a place that we are today.

MS. WILENSKY: And I'm astounded as though this were something new. There have been assumed productivity increases for decades in the payments and, you know, it's like: they'll figure it out. Since we are not very good at measuring actually what happens I don't know we ever know because of the service nature of what is being provided, yet alone are our data limitations.

But I mean for years there's been a presumed productivity increase built into PPS updates, and other updates without -- I'm not sure how much that's ever studied, but it's not like this is in any way anything new. Hospitals certainly have had that for many, many years.

MS. FISHER: Yes. I would just add one, it's Medicare margins for hospitals are negative, they (inaudible) positive because they are getting money from other payers, so it gets a little bit tricky because of the nature of the hospital industry. And I think productivity, at least for hospital inpatients, for the most part is reducing length of stay, because that's where a large amount of the costs are, in the per-day costs.

And I think we have seen more movement into the outpatient settings, part of that is technology, and the research has enabled things to move to the outpatient, but part of it is, you can only you can only reduce the length of stay for so much until things have to obviously move into the outpatient setting.

And I think that gets a little bit harder on the physician side, about how you sort of do those efficiencies, the result and what people, most people view is better care. And maybe that is the reason why when physicians look at what productivity enhancements they can do, they look towards APMs versus what can they do within the actual physician fee schedule.

MR. POSER: Just to follow up. You might want to look at the nursing homes --

MR. GINSBURG: Carl?

MR. POSER: Yeah.

MR. GINSBURG: You've been on this long enough.

MR. POSER: Okay. Sure.

MR. GINSBURG: Bob had a comment had a comment on what Gail said.

MR. BERENSON: To make a comment on one of Gail's points. It is right with -- in fact I'm updating what's called BETOS, for any of those who have ever heard of it. My obituary will lead with BETOS, the Berenson-Eggers Type of Service system. And in fact right now I had to deal with 9,500 codes in the Physician Fee Schedule, with those that are being dropped, and those that are being added.

And so Gail, you are absolutely right that they tend to be micro units. It's not inevitable, it's a technical matter. So you do have 90-day globals; the experience hasn't been terrific, if anything the innovation has occurred, that care has moved outpatient, but we still assume X-number of inpatient follow-up visits as part of that.

So there, it has been that the payment hasn't caught up with the innovation. The other

example is, we have, for decades, been paying renal physicians a capitation for managing dialysis, and under Tom Scully's watch somebody figured out that they weren't actually seeing the patients very often, and so the codes had to be modified to also throw in the number of visits performed in the month. So, just as a technical matter, it's not inevitable --

MS. WILENSKY: Did it make any difference?

MR. BERENSON: I don't know what the outcomes have been. I think they are seeing the patients more often, but in any case I think there's probably a fundamental problem of thinking you can go to aggregated payments in a fee schedule, but I just wanted to clarify that as the technical matter you could you try.

MR. GINSBURG: You have a question?

SPEAKER: Yes. Hi. I've been involved with some of the CMMI models that are being developed in different, very different realms, and one of the things I keep asking is: what about co-payments? How are the co-payments going to work? How is that going to be folded in? And the answer is: we'll figure it out at the end, it seems to be. Not to diminish anybody, but that feels like the thinking. And it started worrying me a little bit until someone said, no one pays the co-payments anyway; they all have secondary insurance, and there's like five guys somewhere who actually pay their own co-insurance.

And it got me back to thinking about a colleague at PPRC who wrote a really -- did a very impressive analysis in the early '90s about the cost to Medicare of some supplemental insurance, because beneficiaries aren't, in fact, very price sensitive when they have a secondary insurance. So, is that part of what we should be talking about? Like, besides how we pay doctors, is what skin in the game should beneficiaries have, and what difference could that possibly make in the presence of secondary insurance?

MS. WILENSKY: Well, somebody needs to have an incentive, and if you -- I mean one of the problems is that when you pair fully-insured for at least the services that are covered, as we all know there are a lot of services seniors use that aren't covered at all under Medicare, but for those that are covered they are usually pretty fully covered because of supplementary or secondary insurance.

When you pair people like that with fee-for-service physicians you have a bad potential

dynamic coming together if you pair individuals who don't have financial reasons to consider the volume of services that they're using with a group that is at some financial risk, especially if there's financial risk with some outcome. I was only half-kidding of, well did it make any difference that the renal physicians were seeing their dialysis patients less. Maybe they were better off that way, I don't know.

That you have a dynamic where you have at least one side of the two potential groups that is looking at the number of services; so, so I mean you can have both, there are a lot of reasons why it's hard to get, especially in the senior population. People who want to have, or feel it's appropriate for them to have a financial stake, but you would like to have then the clinicians, or the setting that they are going to be mindful of what is going on.

MR. BERENSON: One of the barriers to the chronic care management fees that went into place, or one of the concerns the Agency had at a time, that the Medicare statute says that for every service there shall be a co-payment of 20 percent. And a lot of the things that we care about and we want to see happen within the fee schedule development; is that we incent care coordination, we incent services that aren’t necessarily visible to the patient.

And the staff at the Agency at the time was really concerned about the fact that a beneficiary might get a bill for a service that he or she never saw, and how would they react. I don't know what the experience has been since the chronic care management fee has gone into place, and maybe physicians don't bother collecting the fees, even though they are supposed to because of that patient pushback.

But I think that's the kind of discussion that we should have, is what is the role of cost-sharing within the fee schedule? Do we need to have every service have a cost share that we want to waive for some? But there is that dynamic that people expect to pay for a service out of their own pocket when they actually see that care being delivered directly by the physician, and actually we solved that issue but it came up certainly during the time of the chronic care management fee development.

SPEAKER: Hi. I was very intrigued by sort of the undercurrent --

MR. GINSBURG: Could you identify yourself, please?

SPEAKER: I'm Dina Pascan, and for many years I was an employee of HHS. I'm now retired. So, I was intrigued by the discussion, first innovation, and whether in fact the fee schedule

inhibits innovation. And I will say at least in the area of tele-medicine and tele-health that I've worked in for many years, it does, by and large. And the question really comes down to, and I think Bob got to it a little bit, you know, you don't want to pay for every email, and you don't want to pay for every phone call, but the question is: how do you take innovation and make the most of it for the Medicare population?

And I've got to tell you, there's a lot of innovation in payment now going on in some of the private payers, and my concern is, are we learning from that for the Medicare population, to see how, in fact, we can incorporate the digital, as Eric talked about, the digital revolution that's occurring, into in fact making practice more efficient and effective for this population.

And that gets a little bit to also what Gail -- who has left -- talked about her concern that the fee schedule may be inhibiting that. And so, if there are any thoughts you have right now, about how we might take this next step and learn from what's happening in the private sector, and take it in to the Medicare population?

MR. SCHNEIDER: And maybe I'll jump in with a brief comment. Just that the Commonwealth Fund has been studying this delivery system reform efforts around, in particular, I think the Medicare Advantage. So we have case studies and other we are making other attempts to try to share what are the lessons learned as companies like Iora, CareMore, ChinMed, are actually taking risk under Medicare Advantage contracts and then developing these innovative care models.

Whether that informs how we think about the physician fee schedule and valuation, I guess that's the loopback I was trying to make, and we don't have material on that, although I think that's something that would be interesting to develop.

MR. BLUM: The other point is that the Center for Innovation that was authorized the Affordable Care Act, was really the purpose to take ideas outside of the traditional fee schedule process and test and develop, I think there's no limitation that I'm aware of that you couldn't test different telemedicine reimbursement policies. We don't have to have care redesign tied into or, you know, different delivery designs tied into these payment models that we test.

And so if there is desire to test better ways to pay at the micro or, at the individual service like telemedicine, the Innovation Center has that authority. And I think some that it developed it really wanted those models to come forward, and so I think you, as a right -- as a citizen and taxpayer, you

have the right to suggest those models to the Innovation Center, and would encourage you to do so.

MR. BERENSON: (Inaudible) medicine for rural areas?

SPEAKER: Yes. (Inaudible).

MR. BERENSON: Fee fee-for-service?

SPEAKER: Yes, fee-for-service. I just want to make one point as we've talked today about the disparity of income between primary care and specialties, and so on and so forth, and I think there's a tendency to think that when we talk about better payment for primary care, what that really means is more money in the doctors' pocket. And that's a mistake in a way, because the other aspect of this is paying for infrastructure that people need in order to meet the expectations of the evolving care system.

And even things like being able to report quality measures is not simple and you need people that you have to pay to do that, and I think that there's no question that in primary care the fee schedule, and the inadequacy of the payments to primary care, has retarded innovation in primary care, because of the inability to afford the infrastructure that you need to do the care.

I mean try a practice in geriatrics; a doctor can't do that by himself, him or herself. You need staff, you need resources, and it's not only an issue of how much income people take home, but what kind of infrastructure, what kind of environment they are able to practice in. I guess that's not a question, that's a comment. (Laughter)

SPEAKER: So, just a comment to Eric about the impact of innovation. So, having lived through the deployment of a very dysfunctional EHR, and having shared this experience and learn from the experiences of my colleagues throughout the country I am quite skeptical, honestly. It's going to take us a long time to figure out how to optimize technology in medical care partially because institutions and enterprises have already sunk, literally, millions of dollars into systems that they are loath to walk away from.

It's just kind of one of the scariest aspects of high tech. But I wanted to just go back to the kind of focus on value-based outcomes. So, I was intrigued by Simeon's comments about the U.K. experience, and 90 percent of the primary care docs are achieving the criteria.

And then I thought about, what you said, Karen, about how people have walked away

from MIPS. Honestly, I was totally not surprised at all. I think that the model in the MIPS is just terrifying, and I think that the effect to sort of herd people into enterprises was -- I predicted this a-year-and-a-half ago, I knew it was going to happen, because people look at those metrics, and they look at how closely narrow it was going to be at the top.

So, I think, my guess is that the fear, and just like people's thoughts about it, is that we've entered in just yet another sort of dark hole here, and so we are still trying to figure out how to make the fee service work now a-quarter-of-a-century later. There's some pretty clear problems and I worry that we are sort of now -- sort of shifting to this new, you know, we've got a new love here, we've got a new relationship with somebody, and it looks so attractive and so compelling.

It's so nice to think about value-based payments, but it's inoperable, it's like teach to test. I mean, I think we all know what's happened with education, is that there's been this real shift toward the curriculum-designed specifically to pass high-stakes testing at the sacrifice of like, arts and literature, because those things are not easily tested or not tested at all. And I think we as a profession, and especially as leaders in this sort of movement forward, need to kind of look around and say: what have we done here? Have we created something that's going to plague us with a whole other set of problems?

And I guess that takes me back to, what I think is Bob's thesis, is that, you know, maybe our energy would be better spent trying to make sure we did this one thing right because if we don't get this one right it's going to hang over our heads forever, and if we spend now our energy focusing on something new, based on a very flawed system, could we end up in an even deeper hole that we are in right now?

MR. SCHNEIDER: If I could just weigh in on the technology piece, because I think, and especially as we've said earlier, I think that EHRs were just glorified billing systems that had a documentation aspect to them. But we've also written an article on the IT Productivity Paradox, in health care specifically, and the insight there is that it's not about digitizing the existing workflow; it's changing essentially the staffing and workflow, based on the opportunities that the new technology presents.

So, you are absolutely right, it will take time for that to happen, that's not a slow or easy process, but if you look over the last hundred years, the introduction of any technology, there's this sort of 10- to 20-year period of experimentation as people try to figure it out. And that's the sense in which I

worry that the PFS can get in the way if it's locking in existing workflow patterns, when what we really need to think about is how, through maybe CMMI, or other demonstrations, how to actually redesign the way we deliver care based on the technological capabilities that exist to do that, whether it's moving care to the home, or moving care in other settings.

MS. FISHER: The other thing that I would say is, what I worry about a little bit, or that we should maybe acknowledge is, now that we've been in these systems now for many, many years, how sophisticated people get to understand how these systems work. So, for example in the hospital we did DRGs back in '83, there was a wage index, people didn't pay too much attention to that, or if they understood it, and now everybody understands exactly how much money moves through the Hospital Wage Index, and to make any changes to that is very, very difficult because people know, and they are very sophisticated about how it works.

MedPAC on the process expense, I think, several years ago said, well, let's go out and we'll get volunteers, and we'll try to do this thing, and it was very hard to do because people now understand exactly how important the practice expense is, how important the GIPSI is. And so I think, as you look and say, well, let's look at -- let's relook at doing this, my only worry is, is that we are much more -- it seems that we are much more sophisticated, there are many more consultants who are around who can say, this minor thing actually makes a very big difference, so go in and fight that issue.

Where, it seemed in the '80s, maybe I'm wrong, but there seemed to be a little bit more freedom because people -- hospitals and physicians weren't exactly sure what was going on, that people could just put the system together. And I think now we are more in a fish bowl, so to be able to make some of these changes I think it's going to be much more difficult, and much more difficult politically.

MR. BERENSON: But I would say you're making an argument for why we need to get empirical data rather than relying on -- you know when Shaw was doing his study he had very good participation, and nobody knew what the game was. So, I think that -- So it's difficult, Steve emphasized it's difficult to get the data, but I think you could be done. And, again, I would just argue if you're spending $90 billion dollars, don't you want to base it on something objective rather than some estimates from 30 or fewer people? That just doesn't make sense to me.

MR. GINSBURG: This might be a good time for me to bring this to an end. I want to

thank the Commonwealth Fund for its supports. And also mention how great it was to work with Eric and Shawn Bishop from the Commonwealth Fund. I want to thank the three other collaborators, Bob, Katie Merrell Steve Zuckerman, who worked to plan this conference. And thank Staff, Jason Fast from the Urban Institute; Marcie Gabello, and Abby Durek (phonetics) from Brookings.

And I want to thank this panel for a very stimulating discussion. (Applause) And we are adjourned.

* * * * *

CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Carleton J. Anderson, III

(Signature and Seal on File)

Notary Public in and for the Commonwealth of Virginia

Commission No. 351998

Expires: November 30, 2020