

THE BROOKINGS INSTITUTION

HOSPITAL PRODUCTIVITY TRENDS:
IMPLICATIONS FOR MEDICARE PAYMENT POLICY

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P R O C E E D I N G S

MR. GINSBURG: Oh, good morning and I want to welcome you to Brookings. I'm delighted that you're here and the start of today's topic really goes back to the hospital productivity trend assumption in the Affordable Care Act and there were some predictions when that came out that this would be doom for the hospital system. Hospitals will go bankrupt.

Two things appeared to have happened to date: one, is that hospital Medicare margins have dropped, but the other is that hospitals overall margins have not. And an upshot has been growing divergence between Medicare rates and commercial rates, which likely is not a healthy development. So, we need to analyze and better understand hospital productivity trends. If the productivity trends are coming in the form of higher quality of care, does that mean that we should pay higher rates, or should we tie more of our payment to value approaches so that quality improvements that are valuable actually get rewarded only when they're achieved. There's also the possibility that increasingly concentrated markets mean that Medicare rates have less of an impact on costs than earlier research had suggested. Has a degree of consolidation been reached that regulation of hospital rates needs to be considered?

Anyway, we've got -- and just to tantalize things, we have a very compelling lineup of speakers for this conference. We're going to begin with a presentation by John Romley, a Professor at the University of Southern California and the Price School of Public Policy and a key affiliate of the Schaffer Center for Health Policy and Economics. He's going to be synthesizing the literature on hospital trends, giving his interpretation, and we'll have two reactors to John's presentation. And also, John gets the prize for being the most jetlagged person of this conference. He came in from Hawaii, so be easy on him.

Two reactors, my colleague, Louise Sheiner, who's a Robert S. Kerr Senior Fellow and Economic Studies at Brookings and the Policy Director of the Hutchins Center on Fiscal and Monetary Policy. And the other reactor is my former colleague, Chapin White,

who's currently an Adjunct Senior Policy Researcher at RAND. Then we have a panel on the policy dimensions of hospital productivity trends. Louise Sheiner will moderate and it will include, in this order, Paul Spitalnic, the Chief Actuary at CMS; Jim Matthews, Executive Director of MedPAC; Chapin White, doing double duty, and Stuart Altman, now Chairman of the Massachusetts Health Policy Commission and a Professor at Brandeis and many years ago, the Chairman of the Prospective Payment Assessment Commission, one of the predecessor commissions to MedPAC that annually wrestled with these issues. John.

MR. ROMLEY: So, I'm fortunate that my works brings me to a tropical environment. Thank you for the invitation, Paul. So, I'm going to talk about productivity, focusing mainly on hospitals, but also trying to think a little more broadly. This is a big topic to be sure, and I'm not going to be able to do it full justice so, if you're one of the folks whose papers I don't discuss, I apologize, but I'll do my best. Okay.

So, as a society, we have finite resources to try and achieve the things we want to achieve. So, we can think of various combinations of health that we might achieve through devoting resources to healthcare. Keep it simple. Healthcare ignore health habits and other things. And what we don't use for that we can use on other good stuff, right. We might devote 0 percent of our GDP towards health. We might devote, at that dot on the curve, all of it and if we think just about healthcare, we're around here. There we are. Here, suppose we're at this point and then somehow, we get more productive at producing health. And then the combinations that are feasible look something more like this, and that's great. The sweet spot would be, well, here's higher quality. Oops, that didn't work. Good enough. That's lower cost and then the dark line is sort of that sweet spot; higher quality, lower cost.

Several years ago, the Institute of Medicine revisited the question of geographic variation in healthcare and do we want to do geographic adjustment for value and that kind of thing and sort of the preface to that report, and Paul served on that panel. The preface to that report was, well, ultimately we can't just cut willy-nilly. We need to figure out how to get more value out of the system. So, that dark line on that sort of the

possibilities frontier, that segment of it, is sort of consistent with that view of the world.

Okay.

So, there's a big debate about the future of productivity growth in the U.S. I'm not going to get into that. I'll just note that Hutchins is really contributing mightily to that debate. BLS does -- has applied a rigorous, well-developed, careful approach to looking at productivity growth across sectors of the U.S. economy. So, here is manufacturing. People tend to think of it as dynamic here, is a Tesla plant may be representing that well, positive, substantial productivity growth over about 20 years. Here we have services, it's a grab bag of things, but maybe the classic example is a symphony, an orchestra, here's to LA Phil, and here we don't see a bar, right, because we're right at 0 percent.

And then, BLS actually finds, not just not positive, but even negative productivity growth for hospitals and residential facilities and nursing homes combined. So, that's pretty striking. This is consistent with the notion that first comes out of Baumol and Bowen of a cost disease, right. So, you have sectors where you don't see new technologies coming along that generate efficiencies, at the same time, you have to pay people to work in those sectors or they do something else. And so, certain sectors will just see ballooning costs and healthcare has certainly been one of those areas that's been discussed for this kind of issue, right. So, and then this -- that cost disease view of the world does -- has made its way into how people think about health policy in the U.S.

So, a number of years ago, in the 2014 Medicare Trustee's Report this issue was taken up. What is -- thinking about the solvency of the Medicare Program, what do we expect for long-term productivity growth in healthcare versus the rest of the economy? And you see a substantial difference in what was projected. Okay. So, Paul alluded to this fact, that the ACA ties the annual updates and reimbursement to productivity growth. The thing is, is productivity growth in the broader economy, so, the ACA almost says, it's on you hospitals to figure out how to keep up with the rest of the economy. If that's not feasible, that may generate some concerns about the viability of healthcare providers.

At one time, the CMS actuary projected that a non-trivial fraction of Part A institutional providers would develop negative margins under this policy going forward. Most recently, MedPAC recommended an increase in hospital payment rates above the statutory formula due to this kind of concern. And so, this debate has been percolating for a good while about what all this means.

In terms of literature, I think a good place to start, is there was a nice special issue in the 2000 Healthcare Finance Review on productivity measurement. Here's a study by Fisher, looking at physicians, and it more or less follows the BLS approach. So, you have these different kinds of goods, how do you compare healthcare to automobiles or physicians to hospitals when, you start with total output as measured by revenue -- dollars. So, that's something that's comparable. And to move from nominal dollars to into real dollars you divide by a price index. So, this is nice. It's grounded in theory, assumptions of competitive markets. In many cases, constant returns to scale, you know Halton who's one of the leading thinkers in this area, calls this top down because it starts with aggregate macro data series about various economic sectors.

So, what we see here, Fisher found, was not necessarily always negative productivity to growth among physicians, but lagging the broader economy consistent with this concern. Here we have a couple of folks from the CMS actuary's office looking at alternative approaches to measuring productivity growth in hospitals, similar sort of BLS type work and found either no growth or negative growth depending on exactly what you did. But the thing is, that productivity growth is very hard to measure, particularly in healthcare, right. So, Chad Syverson in Chicago has made a career by looking at productivity in the cement concrete sector, right. So, maybe not the sexiest sector, but because he's a social scientist, can't do physical science experiments, he was very smart to focus on a simple sector where there was nothing else going on, right. We don't have that luxury. Right, there may be trends in unmeasured aspects of the quality of care, right.

We ultimately don't care about the inputs, we care about the health it's

produced, right. So, maybe hospitals and others have been using more resources, but to achieve better outcomes, right, and they're not getting credit for the benefits, but they are getting blamed for the costs. Or maybe there are trends that have not been captured in terms of how severe patients are, right. So, they show up at a hospital or another setting with health history and health habits and that ultimately affects how things turn out. And really, the existing evidence, in my view, I can elaborate on this if anyone wants, doesn't really deal with these issues. As great as the BLS approach is, healthcare is kind of different and it doesn't deal with these issues as one might hope. That's how I guess I would put it. So, anyhow, my colleagues, Dana Goldman (inaudible), we took up this issue again in a study that came out in Health Affairs, looking at 2002 through 2011, elderly Americans in fee for service Medicare, and combining health insurance claims, administrative records and regulatory filing. So, the nice thing about this, is we can see when people go to the hospital. What their long-term outcomes after discharge are. We know where they live, so, some sort of context about their socioeconomic, determinants of health, that kind of thing. We look at a range of important conditions and have some risk adjustment that really, right. So, some of that earlier work, they might look at DRGs, big, sort of relatively big buckets. But there's a lot variability even within a diagnosis. So, we are going to use -- we used open source risk adjustment. That's a very contentious issue, risk adjustment. How to do it, but I think most people would agree that you need to do something. And that's something that we do here. Okay.

So, the very first thing that you might do is just look at cost per discharge. That's sort of the inverse of productivity, right. And here we see across the board for these three conditions, not rapidly increasing costs, but they're all upward sloping, right. So, we go from about \$18,000 to almost \$19,000 for heart attack, for example. That's not suggestive of productivity growth. Next thing we do is, regression analysis because we want to figure out how different approaches might lead to different results. So, this is what I would call sort of bottom up because we start with, rather than macro data series, we start with patients and

providers. Here in our regressions the unit of analysis is a hospital year and you don't necessarily have to assume returns to scale because in a regression you can relax that. In this study, we don't. We do assume returns to scale, but in our later work we haven't done that.

Anyhow, when you do the naïve approach, when you think of hospital output as just the number of stays for these various conditions, we see negative productivity growth across the board. In fact, for heart failure, we nail that BLS number exactly. I mean, I wouldn't make too big a deal out of that, but it's kind of consistent. Okay.

So, the next thing we do, is adjust in our regressions for patient severity, again, I don't want to get in the weeds on that, but I'm happy to talk about it at some point, and things do change a little bit. So, for both heart failure and particularly for pneumonia, the picture is more positive. Still negative on net for heart failure, but less negative. So, that suggests that the patients are showing up sicker and the naïve approach was not accounting for that.

And then finally, we define the hospital output by the number of high-quality stays. What do we mean by that? Well, a patient had to survive 30 days beyond the admission and that did not show up well and avoid an unplanned readmission within 30 days of discharge. And obviously, these are very policy relevant metrics for CMS and others. So, when we do that, we're now looking at the blue column -- so blue bars, and we see positive and even substantial productivity growth across the board. So, this study suggests that how you do it really does matter.

Now, I should note, I should acknowledge that quality of healthcare, worrying about that, we're not geniuses who are the first people to think of that, right. So, going back to a couple of decades now, the Boston Commission was thinking about does the CPI which is used to determine COLA increases for Social Security payments, does that overstate the real -- does that overstate the true rate of inflation in the cost of living. The cost of living meaning, achieving -- the cost of achieving a particular standard of living. A

primary concern there was technological change and the quality changes that were associated with that, healthcare is a part of that story and so, David Cutler and colleagues looked at the price of heart attack treatment and found that accounting for better outcomes, the price of treatment decreased, okay. So, this is what's called a cost of living price index and without getting into the weeds, I'd say it's really closely related productivity, but not exactly the same thing.

Louise actually has a nice paper sort of talking about why, and I think she's right, why productivity and sort of the BLS sense of the word is really what you want to be thinking about when you're thinking about payment adequacy under the Medicare -- for Medicare. Okay. So, anyways that was hospitals, right, and maybe what this cost disease will manifest itself when we look at nursing care, right. Very, very low tech. Not changing a lot over time. Okay. So, we do the same kind of thing. Looking at patients who are hospitalized and then first sent for post-acute care to a skilled nursing facility and look at their outcomes. Now, quality's going to be surviving 90 days beyond the discharge. Avoiding an unplanned readmission and discharge to the community -- return to the community by the end of the stay or the end of the episode. And so, we kind of walk through the various specifications; you see something very similar, that by the end of it, for these post-acute care intensive conditions, joint replacement, stroke, hip fracture, you see actually a substantial productivity growth when you account for the quality for the outcomes that are achieved. So, I'll try to talk briefly about where we might go from here.

Clearly quality has to be part of the picture going forward. I would say that even if particular settings are doing well, we do worry that the healthcare sector has all kinds of problems with information and coordination and that kind of thing, and so, some of the reforms or experiments in the ACA are trying to improve on that margin, right. So, let's do bundled payment. Let's pay for populations, that kind of thing. And so, I think we want to move in that direction, beyond encounters, towards episodes of care and population health. I think we want to look at new populations in context, so, Medicare is important for sure, but

to a degree it's like looking under the lamppost for the keys. It would be nice to look at Medicaid. It would be nice to look at the commercially insured. Childbirth happens a lot in this country and we have a maternal -- a serious maternal mortality problem. It would be interesting; I think, to look at that. Analytically there's this issue of top down versus bottom up. I don't want to get in the weeds on that. It's not just limited to healthcare, it's for all of productivity measurement, that issue, but it does play a role here. There are challenges with respect to the multi-dimensionality of quality. What's the trade off between quantity and quality. I can talk some more about that.

Something that often comes up is, well, what's behind all of this? And I agree. That's a million-dollar question. And so, we want to assess what some of the potential drivers of productivity. Have some of these innovative payment and delivery models, help things, right? Questions like that. I will say that scaling up beyond the early work that we've done, that is a very data and labor intensive project and so I don't want to end on a downer, but it's a little -- I've wanted to get to this for a long time, but there's just a lot of work to be done here on this important issue and so, thank you very much for your attention today. (Applause)

MR. GINSBURG: Okay, I think we have five minutes questions. Anyone? Back there, please. And someone will bring you a -- there you go.

MR. GAGLIANO: Thank you. Lou Gagliano of the CTAC. A question about geography and places where value based contracting and hospital reimbursement are tied to quality outcomes, like patient infection rates and others. Can you comment on why certain states and areas where that's more prevalent in terms of incidents, meaning value based contracts and pointing people to go to those hospital's where better care is given is measured by some of the things that MACRA is measuring? Have you done any work to look at those geographies and reached any conclusions?

MR. ROMLEY: That's a great question. So, I guess two comments. One -- the first is we have -- here's a study, Paul is co-author on this one, that looks for acute care

for heart attack, looks at geographic variation and probably not surprising, we do see wide variation of dark green regions are high value regions. One of the things you'll see though, is that some of the high value areas are actually low quality, but low cost and some of the low value areas are high quality, right, so, there's not exactly a tight relationship necessarily, which I think is policy relevant. So, that speaks, I think, at a high level to your question that you have, but not exactly your question. Your question I think is about what are -- how do contracting practices vary across the country and what are some of the metrics that are tied to -- and I don't -- honestly, I don't have a great handle on that for the commercial side. I would look to some of my fellow speakers to maybe take that up when they have the opportunity, but I think it's a great question. Anyone else? Back here, please.

SPEAKER: To what extent were the severity adjustment factors you use actually picked up in the payment rates for Medicare or were they something apart from that?

MR. ROMLEY: Right. So, there were three broad classes of risk adjustment. One, I would say, is sort of the simple demographics: age, sex, race. Another is because we knew where people lived and there's this interest in socioeconomic determinants of health, is we would link people to their zip codes, census data on poverty and education and employment, okay, and then the third group, and I think the most important group is sort of diagnostic type stuff, which is not surprising. Standard comorbidity indices. Probably the key one is, for each of these conditions HRQ tasked clinical experts with developing risk adjustment algorithm that could be used in administrative data by hospitals themselves or others to sort of assess their performance. You don't need the rich post discharge data that we actually are fortunate to have. And so, here is the risk adjustment model for -- those are the parameters we won't interpret them, for AMI heart attack. You can see what goes into them. So, it's age, is there a transfer and then APR-DRGs. So, those are related to DRGs, but I think more fine grained. It's a bit of a black box because this comes from 3M and the underlying algorithm is not open source. They just

give you the tool to run the data through. So, I think there's -- what I'm inclined to say is that most of this is happening under the hood of DRG adjustment. Anyone else? Thank you very much.

MR. GINSBURG: Okay, we'll bring our reactors up.

MS. SHEINER: Great. Paul, thank you so much. Thank you for having me. It's one of my favorite topics is thinking about both productivity and health care. And so, this is everything I love all together. So, as John mentioned, Paul mentioned, the background to this is that the ACA lowered the statutory updates for most non-physician providers. It used to be that the official update was the changes in input costs. They didn't actually always do that, but that was at least what was in legislation and then the ACA said, no, no, no, you should be able to get productivity growth, and if you can get productivity growth then we can pay you less and you should be able to produce the same amount that you were producing last year. So, the idea kind of behind it was, this is the payment rate that should allow you to give a constant level of services, right. So, when we think about things like Social Security might say, oh, we want to find the right inflation index so that the constant level of benefits for people over time, this is kind of doing the same thing for healthcare. Now, because measured productivity growth in the hospital sector is extremely low, there were wide spread concerns that this payment would be increasingly insufficient over time, right. So, this is something that it -- if productivity isn't as high as a (inaudible) productivity, then it's not enough to keep up with costs and it's cumulative. Every year it's not enough, it's not enough, and it gets to be quite large over time. So, that sparked a whole debate about hospital productivity and how to think about it. So, as John said, I think there's huge mismeasurement in many aspects of the economy. So, he talked about a project we have at the Hutchins Center, which is looking at mis-measured productivity across multiple aspects. One of them being healthcare, where I think most people think the mismeasurement probably is the greatest. And so, what John did was, he calculated the change in cost for successful outcome after adjusting for case severity, and when you do that productivity

growth is much higher. So, that's the first thing you might think about doing as well. Instead of saying I care about healthcare, what I really care about, I care about successful outcomes. So, if I'm going to define that as the good that I'm buying, then I can look at price of that good and see what's happened to that over time and so, prices and productivity kind of go together. If the price of that is coming down it's because the health system is able to produce the same thing for less and therefore, productivity growth has increased. Okay.

And so, John's work, he's done a lot of stuff. He just presented some of it today. It's a really important contribution; understanding hospital productivity. It's the kind of stuff that we have to do a lot of. He's involved in our project. So, this is a nice area that works for both of us. So, I think though, he said I didn't agree with him, but I actually think that his measure likely underestimates what I would call the true productivity growth. Because what productivity growth should be is when the economy can produce something that it couldn't produce before, it's a John showed you in the picture, it's an expansion of that possibilities frontier of what you could have, okay. And it's possible that you can actually be better off and the economy can produce things that it couldn't produce before even while John's measure of productivity will show that productivity has declined. And so, here's an example, so imagine in the first year a treatment has a 20 percent probability of success and it costs \$5,000, so how much is cost for successful outcome, plus \$25,000 per successful outcome. If you only get one of the five. In the second year the new treatment has a 50 percent probability of success. It costs \$15,000. The cost for successful outcome is \$30,000. It went up. So, that looks like a bad thing, right, but let's say the successful element meant you had an extra year of life. So, between year one and year two you get an additional point three years of life for an additional cost of -- oh, I made a mistake here -- \$5,000. I'm so sorry. So, if the year of life -- let's say it were \$10,000, it's not, but -- if the year of life were worth it, if it was \$10,000 over point three, then the healthcare would be more valuable in the second year than the first. Even though the cost per case has gone up. And the idea being, in most things, if you tell me what the cost of a car is, I can buy as many

cars as I want at that cost, right. So, if the cost of a car is \$20,000 then I can buy ten cars if I want, right. But if the cost per additional year of life is \$10,000, I can't buy as many of those as I want, right. I can't buy 100 years of life at that cost, and so, what happens sometimes is that the technology allows you to have something that you couldn't have, and even if the price of that is higher, in other words, now I can have a second car, not for \$10,000, but for \$15,000, but if I couldn't have it last time and now I still want it, then you're better off, right.

So, it's a different way of thinking about what productivity looks like and what a deflator might look like. And here's an example of work -- comparing different ways of looking at it, and this is from data done at (inaudible) Hall and they sort of compare two different approaches to measuring the price that you would use to deflate. And so, John's is kind of a cost per successful outcome that sort of middle line, and the top one, is unadjusted. So, John basically said, look unadjusted prices aren't increasing, but adjusted prices are going down, productivity is higher. If you think about the welfare approach, you actually get much larger price declines and much more value from the health system, right. So, if we're thinking about, is the health system producing value. We're spending a lot more. Are we getting value for it? I think the answer is, for the things that we've looked at, and not everything has been done, but for the kinds of conditions that have been looked at and you're using value based on mortality or quality of life, the answer is yes, we've been getting value for it. Okay.

So, the question is what the implications of that are. So, if we start at the productivity growth is less than the economy wide productivity growth then you have a problem, okay. Either Medicare beneficiaries will have less access or there will be more cost shifting, and so, there'll be pressure on the system, all right. But if the productivity growth is higher than the economy wide multi-factor productivity, then the (inaudible) will actually be sufficient to finance constant or even a growing quality of care, right. I mean if productivity is growing quite rapidly, then it's possible that we'll still have productivity growth and still have improvements of quality even with the Medicare payment updates, okay.

But that questions whether or not that's enough. And I think we'll talk a lot more about that some in this panel, which is the sustainability isn't just about whether or not the system can produce a constant quality of care, right, because we actually live in a system where you have Medicare and we have other payers, right. And so, if the other payers are saying I don't want a constant level of quality care. Healthcare's really, really valuable and people are willing to spend a lot of money to get those marginal improvements and therefore, they're paying a lot, then you have this growing divide of what Medicare will pay and what the private payment will pay. So, one question you might ask is, well, if we're getting all this value on it, what should Medicare be doing? That's a little bit of a separate question. But so, if you think about that this sort of growing wedge between what private payers will pay and what Medicare will pay, then you wonder what happens, right.

So, I think we'll talk a lot about it, but one thing is that maybe Medicare is able to free ride on private. The private's pay a lot. The hospitals say I can invest in new machinery and new procedures. Everybody gets it, so Medicare can free ride. The question is, how long can that go on for? Maybe beneficiaries access Medicare will be limited. It's like, oh, the private payer pays so much more so I don't want to see a Medicare patient, I'd rather see a private patient. Or maybe because we're all worried about what we're going to do about health spending that keeps growing and growing over time. At some point, these things may not be worth it and Medicare -- private payers may actually follow Medicare's lead and it might be easier for them to actually cut back. If Medicare is not paying a lot, then that gives private payers more negotiation power with hospitals. So, you might see it going from Medicare to the private sector.

Okay, I'm out of time, but let me just quickly conclude, which is I think it's pretty clear that a productivity mis-measurement in health care is large. That productivity growth in health care is much larger than any official measurements especially when you're thinking, what are we getting for it. Is real GDP in terms of what people value growing as a health care, I think the answer's quite clear. I think that doesn't answer the question of

sustainability though and so that's part of the question, but it's not the full question.

And this complex interplay between Medicare and other payers just makes this question hard to analyze. Thank you. (Applause)

MR. MATTHEWS: Good morning. Let's see. We don't have these all in the same slide here. I think that's me. Nope, good and slide show. Okay, okay. Good morning, everyone. Paul, thank you for inviting me to join this group. This is a fascinating topic, hugely important. I only have two slides, so I'm going to try to keep it simple. And I think I want to take a step back from the talk about different data sources and different risk adjusters and get at the core challenge I see in measuring hospital productivity.

And the challenge comes from the fact that we're used to thinking about industries and economics and markets in the following way, that there is human capital, physical capital and technology that determines the cost of production. Picture the Tesla factory floor where you'd have welders and you have robots and you have the assembly line and Tesla is trying to keep its production costs as low as possible. Tesla then markets their cars. They put a sticker on the car and then you have consumers out there who are shopping for cars. They go on the lot; they can see how -- compare the Tesla with the other models. There are competitive pressures that are pushing on Tesla and all the other auto makers to offer competitive price to minimize their production costs. And then as an economist, you come and count the number of automobiles sold and you can adjust for quality and it makes sense to assume that manufacturers are pushing costs down as far as they can and using technology to crank up productivity over time. Okay.

Now, we come to the hospital industry. All bets are off in the hospital industry. That's my big take on it. Why? Because you don't have costs minimizing firms selling in a competitive market. What you have is public policy decisions are setting prices and then based on the prices that hospitals get, that determines their production costs; that determines how much they spend to produce their services and it also determines what kind of technology they use and so everything runs backwards in the hospital sector. That's my

big take.

And the way to boil it down is that hospitals -- how much it costs a hospital to produce a service is determined by how much we choose to pay them to produce that service. So, when you're trying to measure productivity in the hospital sector, it doesn't make sense to start with an assumption that hospitals are pushing production costs down and minimizing their operating costs; applying technology to be as efficient as they can. That assumption is just out the window for hospitals.

It makes it challenging then to try to track productivity in the hospital sector. And what's really challenging is to think about what's possible in the future because if we've been paying hospitals in an increasingly generous way over time. And it looks like they've been getting less and less productive over time, does that mean that we're locked into negative productive growth in the hospital sector? In my mind, no, because of public policy turns around and starts clamping down on payment rates and paying hospitals less, then it's possible that they may become more efficient as a result and productivity growth may bump up.

So, that to me is the really big picture challenge in measuring hospital productivity. But the other big point that I want to make is that measuring prices and quantities, there are a lot of technical intricacies in how you measure prices and quantities. But I think it's important to try to avoid the lure of the new fancy, conceptually pure price measure in health care. And what do I mean by that?

We are measuring prices and quantities for a reason and the reason is to inform public policy and to look at our hospital industry and to make some judgments about whether we're setting prices in the right way or not. Whether we're paying them more than we have to or not. Prices and quantities are also used for other things like COLA and so on, but I think the big picture question that we're trying to answer is, are we paying hospital more and more over time and getting the same, or are we getting more and more good stuff from hospitals over time? And is it fair for them to be paid more?

So, with what's challenging in measuring prices and quantities in the hospital sector is we need to keep the motivating question in mind. What's the motivating question in measuring prices and quality, quantities and the motivating question is, are the prices that we're paying fair? Now, when you're looking at Teslas, okay, we don't worry about whether \$35,000 is fair. If Tesla over prices their cars, they won't sell them and honestly, I don't really care. So, people will buy other cars and the world is fine.

In the hospital sector, we're more or less setting prices and the question is, are those prices fair? Okay, and the concept of fairness is like throwing a skunk in the economist party. Economist just want to talk about disease based cost measures and risk adjustment and so on, but in my mind, the key question is, are hospital prices fair? Are we paying hospitals too much? Are we paying them too little, because remember, we're basically setting prices for hospital care. We're doing it directly in Medicare; semi-directly in Medicaid and indirectly through benign neglect in the commercial sector, let's say. But we're setting health care prices and hospital prices. Are those prices fair? So, my concern about the productivity approach that John has taken and David Cutler has taken, and Allison Rosen, my concern was that it's setting up a situation where you say, yes, we're paying -- we're spending more and more and more on hospital services over time, but hospitals deserve it, they're earning it. They're doing these great things to earn it because the quantity of the positive things we want is increasing over time.

I don't that's really getting at the question whether prices are fair in the hospital sector. For two reasons, one is, mortality may be declining over time. That may have little or nothing to do with hospitals are doing. You may be inadvertently giving hospitals credit for people surviving longer. That may just be education, nutrition. Maybe the opioid epidemic is waning and we may be inadvertently giving hospitals credit for all the incredibly complex things that feed into health outcomes. That's one concern, but the other concern is that I want to think about whether health care prices are fair, thinking about taxpayers, employers who are buying health insurance and the employees who are

producing health care. And that kind of price and quantity measurement is most direct if you're using a very simple service price index.

The service price index says Medicare is paying \$15,000 for DRG 470, which is a knee replacement. Commercial plans are paying \$30,000 for DRG 470 and here's how many nurses and physicians and custodial staff and administrators the hospital has to use to produce DRG 470. If we have a very simple service price index, it's totally backward looking from an economist point of view, but it's a very simple, direct way to say, are these prices fair. And that's the question in the healthcare space. It's a different question than, I think, economist typically set themselves up to answer. And I hope that lands in an interesting place and I'm interested to hear where we all take it. (Applause)

MR. GINSBURG: Are there any reactions to (inaudible)?

MR. ALTMAN: Thanks for those perspectives. They're very interesting. I'll start with Louise. So, I didn't mean to say that we disagree, or maybe I should say that I disagree that we disagree. I think we're mostly on the same page, particularly, the last slide you put up. So, in my mind, what the productivity is telling you is in a payment adequacy context, if the payment update doesn't keep rise with inflation, can hospitals stand still. Can they treat the same patients with the same outcomes or not?

That doesn't mean that they could necessarily do better, right. So, if there is productivity -- so, I guess what I'm saying is where the productivity -- they don't necessarily have to stand still, right. They can channel it into improved quality. I think that was your point. Paul's made that point and that may generate additional value. You can see flat productivity growth, but nevertheless, improve social welfare. So, I think that's also an important question, but sort of the next question from the first question in my mind.

With respect to Chapin, a couple of things. I mean, I do think that you're right, that health care, in particular, hospitals are different. There are public hospitals, there's lots of not-for-profits who may behave differently. I do think your point about being down on payment rates leading to cost reductions that does suggest that cost minimization

is at least to a degree on their mind. I will say in terms of our work, what we are measuring is in a sense, the gap between the -- what's produced, the quantity and the quality of the care and the cost used to deliver it. So, that's what I'm calling productivity. So, if you have inflated costs because you're a little bit too complacent, that's going to be in the cost measure. So, it's -- I think that addresses that one point.

I think it's very interesting, the interaction of the different sectors, right. So, growing out of the IOM work, we actually had looked and saw in areas with high commercial reimbursement, you saw lower Medicare spending and utilization. So, that -- there's this idea that well, maybe if you cut Medicare prices -- reimbursements, you'll just charge commercial insurers, that's the cost shifting view and economists tend to be skeptical a little bit, for reasons we can discuss. But what I'm talking about actually is, it could be on the utilization side because providers have -- they just know a lot more than we mere mortals do and have an informational advantage over us and could deliver care that may be lucrative to them in response to. So, if they're doing well in the commercial side, maybe they'll feel okay dialing back on the Medicare side.

And then, my final comment -- I hope I haven't taken too much time, is this is for Chapin again, I would just love to -- this is -- please take this in the right spirit. I would just love to know how you would define fair in terms of what the right prices would be.

MR. GINSBURG: Okay, next. I think, Fox, Chapin and Louise.

MS. SHEINER: Oh, I have questions for Chapin too. So, at every one of the things that was interesting is you start off with this idea that prices lead to technology, and then you said, but we can make prices fair. And then, what I'm saying is you really want to know what the technology that -- so, if you spend more; if there's more technology and we're getting a lot for it, then you might want to do that.

MR. ALTMAN: Yes.

MS. SHEINER: Sorry.

MR. GINSBURG: You go next.

MS. SHEINER: So, I think it's true that technology is endogenous to prices, but then it's not just fairness you want to ask about. You really want to say, how much should we be spending on health and how much should we be spending on everything else. And when you think about taxpayers, it's the same question, right, so there are -- you don't really have the ability to pick and choose. Well, I'll take this from Medicare and I'll top it off over here. And so the choices that Medicare makes are actually choices for how much care people will get and so I just think you need to -- that I don't think you can ignore the question of, are we getting value for this care? And that's got to have a public policy implication.

MR. GINSBURG: Okay.

MR. WHITE: Well, the question of what's fair, so I just put out a study a month or so ago, looking at commercial prices for hospital care relative to Medicare and when I think about fair, I don't know what the right fair price is, but what I think about is Fort Wayne, Indiana. It's the poster child for high commercial hospital prices. And what you have in Fort Wayne, Indiana is the school district is paying probably \$40,000 for a knee replacement. Medicare is maybe paying \$15,000 for a knee replacement. There's a very -- there's a non-profit system that dominates Fort Wayne, Indiana and they're very aggressive on their pricing. And most of the commercial revenues that hospitals get in Fort Wayne, Indiana is profits. Most of it's profits. And with -- so, the fair question, there's no obvious way to come at it, but I think the school district is being squeezed. Their wages are being squeezed and I think the hospital in Fort Wayne, Indiana is being over reimbursed. Now, they're an outlier, so it's fairly clear that they're off-base, but I think general question applies and the fairness question is getting at employees who are paying for employer sponsored insurance through foregone wages. Taxpayers who are paying for Medicare. People paying their premiums and their cost-sharing. All of those folks are on the buy side. On the sell side, it's nurses, custodial staff, administrators, executives and there's a fairness question here and what I worry about is if we measure quantity as successful stays without a readmission and readmissions drop, does the hospital get to keep the money for the

readmissions that didn't happen? I don't think it's fair for the hospital to get to keep the money. I think we want to push hospitals to reduce readmissions, but we want the savings to go back to the employees and taxpayers and premium payers. That's where we want the savings to go. So, I don't know if that makes sense.

MR. GINSBURG: Thank you. You were saying? I was going to go to the audience for questions, Stuart? Just wait a second so a mic comes to you.

SPEAKER: Help me out a little bit because these were both -- everyone was great. So, Chapin, those two -- your two movements in the private sector in health care in general, what about the producer? So, if I'm Tesla and I think, "Oh, I'm going to be able to sell my car for \$250,000." Based on that I create a car with all the tools, with the fancy stuff like that and I play it out and then, I come to the end of the market place and the market place says, "You can't sell it for \$250,000." Now, I already made this decision the first -- so, what I'm curious about and I'm particularly curious when we get to health care is the loop.

So, now, the market place says, "Hey, you can't do that. Going forward, you have to do something differently. So, then the market place sends it back to the producer and they have to then come up with a different kind of a car or they're going to go out of business. So, we need to look at the producer. Now, I'm particularly concerned about health care because -- so, I'm a producer. Increasingly, the producers are in monopolistic or oligopolistic situations where we've had massive amount of consolidation. So, they're sitting there. I hate to say this because I'm giving my speech, I can go. (Laughter) Medicare is becoming irrelevant. As long as you've got a private sector, thanks to the research that you've done, that basically is saying to the hospital, whatever you charge, we'll pay up to now. And therefore, I'm a producer, I'm a hospital, I'm going to produce what I want and I'm going to pay myself. I'm going to have -- I don't think they're making profits in the class sense. They have higher salaries; they have more people; they have fancier buildings, whatever you want to say. But what I'm concerned about in your models is the producers and how they really look -- and I don't think it goes this way and it surely doesn't go from

public policy to the producers. I think public -- the producers have ignored public policy in the last couple of years.

And if public policy is Medicare and Medicaid, are increasingly irrelevant because of the ability to sort of generate. So, how does this loop work in your models? Everything everyone said sounded right, but I had problems with the looping and focusing on the producers.

MR. GINSBURG: If I can follow this up. Chapin did some very ordinary research on cost shifting when we were colleagues for the Center for Studying Health System Change, with the implication of lining up with MedPAC's research that's if Medicare is squeezed payments; hospitals didn't shift them in the aggregates if they cut their costs. And I was wondering the hospital industry is so much more consolidated now. What's your thinking is, Chapin, about? What's happened since the data (inaudible) research was at the time.

MR. WHITE: That's a good question. We should do the -- update the study, but on the question of -- let's see, is public policy determining prices? Clearly, yes, in Medicare. Clearly yes in Medicare Advantage, indirectly in Medicaid. On the commercial side, I'd say we're actively maintain a public policy that emboldens hospitals to consolidate bill charges at astronomical levels to punish any health plan that dares cut them out of their network. That's a public choice and it's not directly setting rates, but it's benign neglect and it's having a clear outcome on negotiated rates. We're choosing not to apply policy options that would bring down those prices except in vary, like, nibbling at the edges ways, like, surprise billing.

MS. SHEINER: Yes, so I think one of the things that kept on coming up is, is this an antitrust issue that we're worried about, or it is sort of related to Medicare in some sense? And I think that the question is more like what are the implications for Medicare of this consolidation that I think are unclear.

MR. WHITE: Yep.

MS. SHEINER: And it does depend on that loop, right, which is maybe some of it goes to higher wages and fancier buildings. But maybe it goes into more invested in your new technology that you can now afford, which then will have spillover effects probably positive, I think, on Medicare. And so, it's -- I think you're right that -- well, we don't necessarily have a great model of hospital behavior which I think is what you're talking about. And it comes up with if you squeeze them, do they get more efficient? Well, how do you -- why is that?

But I do think that you have to think about that investment in technology, the aspect of it that might not show up right away, but will show up over time, as I think, some of the productivity improvements that John's measuring.

MR. WHITE: So, if you -- well, two things. On the \$250,000 Tesla, so Tesla rolls out their car for \$250,000. Nobody buys it. They cancel the production line. They offer a different car or they go out of business. That there are competitive market pressures that are disciplining Tesla in its product offerings.

In the hospital industry, you have the hospital in Fort Wayne, Indiana charging \$40,000 for a knee replacement. The market discipline mechanism is just completely paralyzed and employers are terrified of switching their health plans; the carriers have these long-term symbiotic relationships with the hospitals and the hospital is raking in these huge revenues and then distributing a lot of the profits to physicians through their own physicians' practices. The market mechanism is paralyzed and the feedback from the ultimate buyers to the producers is going to happen through public policy mechanisms, rather than conventional market forces.

MR. GINSBURG: Yeah, and then actually one more thing is the heavy degree of subsidies to the Fort Wayne lawyers makes them less like to take significant action if their employees may not like to control what they pay --

MR. WHITE: The taxes.

MR. GINSBURG: -- in tax situation. Thank you. Other questions?

SPEAKER: Just real quick. This Fort Wayne example, clearly, we have a complex and highly varied economic environment and that leaves some weird stuff. I'm sympathetic to that. Sort of at a more macro level, you can look across economic sectors and ask, what's the relationship between the return and the risk, the investment risk for that return? There's a professor at NYU and I'm blanking on his name, but he's done this. And so at one end, you have pharma, high risk, high return; at the other end you have traditional utilities. And I will tell you that the hospital industry lies right on the sort of central tendency line. And so, Fort Wayne, you might be way up here, but on average, they're not sticking out in some way.

MR. GINSBURG: Stuart? Has Stu got them in there?

MR. GUTERMAN: Thank you for --

MR. GINSBURG: Stu, can you introduce yourself?

MR. GUTERMAN: I'm Stu Guterman and former MedPAC Deputy Director and Fund, when we funded some of John's initial work. Thank you, for all three of you. Great comments. We've clearly come a long way in making progress discussing hospital productivity and the implications. I'm particularly -- I was struck by all of your comments, but I would -- and particularly Chapin's turning the flow backwards for the hospitals because I think that's the way it goes except I don't think it linear. I think it's a loop, but -- so, perhaps instead of the debate over the term cost shifting is kind of dead, but maybe we should have been calling it revenue shifting all along because of the relationship between the revenue available from the private sector and what it does to cost to hospitals. And so, I would make one point about that, and that is we tend to focus on the concentration in the hospital industry, but there's a lot of concentration in the private insurance industry as well, and that insulates insurance companies from the pressure to negotiate harder on their prices.

They tend to point at hospitals and say, well, it's all because hospitals are concentrated. But there's really very little incentive for private insurance companies to minimize the amount that they pay for the services that they pay for because they basically,

and the ACA kind of formalized that, they're basically limited to a certain percentage profit on their costs. So, if their costs go up, their actual nominal profits go up as well. So, there's really a lot of attention we can pay to both concentration in hospital market and also concentration on the payer market to try and drive down prices to whatever fair means.

MS. SHEINER: Can I comment on that just? So, I think one of the things that's interesting about all of this discussion and bringing it back to the productivity growth, is somehow, sort of these (inaudible) to say, oh, they're just getting all this money and their kind of wasting it, and yet, when you look at the data on saying are we getting value for -- on average, now that doesn't mean you couldn't do much, much better, but we're saying, so they spent getting all this money and they're sort of what they're spending it on seems to be worth it, on average. It doesn't mean you couldn't do better, but and so I think that's an important component to discussion. It brings it back to John's stuff.

MR. STENSLAND: Jeff Stensland, MedPAC. I would just like to hear your thoughts on who should get the benefit from the productivity enhancement? I think in real dollars, and I probably pay less for a computer now, then I did 30 years ago, and Apple gets a little bit of that productivity benefit, but I get the vast majority of it. And if you kind of look at European countries and their life expectancy changes and their wages for the last 50 years, it looks like compared us to them, the consumers got a little bit more of the productivity benefit there. The producer's got a little bit more of the productivity benefit here. How do we look about who should be getting that productivity benefit?

MR. ALTMAN: In the automobile market the consumer gets most of it, right. And I think in the healthcare world, if we can figure out how to push hospitals to produce the same outcomes at a lower cost, hospitals shouldn't get to keep most or all of that. That should come back to taxpayers and people paying the premiums and people paying the cost sharing and so on. So, Jeff, I think you setup a question, but you answered it beautifully.

MR. GINSBURG: Or presumably, you said that consumers should get it.

MR. ALTMAN: Yes.

MR. GINSBURG: The question is what has to happen for that to occur?

MR. ALTMAN: Right.

MR. ROMLEY: I mean one other quick point is, your point, it sort of averts to -- it's been a while since I've done regulatory economics, but in utilities, in rate setting, right, there's this view that we should claw back any gains the utilities make, but what then is the incentive to go ahead, right. So, you could set maybe a five-year cap. They get some return on it and then you go ahead and claw back, something like that.

MR. GINSBURG: Other questions? Yes.

MS. FRIEDMAN: Good morning. Jennifer Friedman. I'm with Striker, the medical device company, but I was with Ways & Means when we were doing health reform, so, I am scared to confess that I take some responsibility for the productivity adjustment. So, apologies to you all. I had a question for Louise because near the end of your slides you had there is Medicare free riding on private payer, which then I had to check your bio and check that you were an economist because that struck me as cost shifting, kind of. And so, I just wanted to part that a little bit and see sort of how that everything I've ever learned from Jim and from Mark Miller and all the economist's about no cost shifting when I was on the hill, I just wanted to sort of flush that out a little bit more and how that sort of how that fit in with sort of what we always hear from all the economists about that.

MS. SHEINER: So, I think that's why Paul said maybe we should have a new name for it. So, with cost shifting is Medicare cuts its payments and therefore private payment rates go up because somehow the hospitals are not profit maximizing and they just need to cover all their costs and they're able to -- they could have had higher private rates before, but they chose not to, but now that Medicare's cut, they're rates are going to go up. That's not what I'm talking about. What I'm talking about is if you think about the production process where you have fixed costs and you have marginal costs, you can imagine that if it's worth it to buy some huge new technology, and you can afford it because the private payers are paying you for it, then at the margin it may well be worth it for you to use it on Medicare

or there maybe norms that say even if it's not, you don't have different levels of care for different people. And so, it's free riding in that sense. It's not cost shifting, but it just says, you know if there's a lot of money in the system and Medicare setting prices the Medicare may be getting benefits that are rising faster than they would get if the private payer set the same prices as Medicare. Did you --

MR. ROMLEY: So, another terms for it might be cross subsidization. So, if we move away from even the payer discussion, within a general hospital we want them to be providing a range of services, right. Not all of those services are equally lucrative, right. Cardiac care is a lot more financially appealing to hospitals than is mental health, and yet, we want most hospitals to be capable of providing some mental health services to their communities. So, it's the same kind of thing.

MR. GINSBURG: Actually, when I teach health economics, I use the term price discrimination. Charging different payer's different amounts, which is distinctly not cost shifting. Yes, the woman on the isle there.

MS. GRAHAM: Hi, Maryann Graham from the Coalition to Transform Advanced Care. A question. So, we've been talking about hospitals and equating health results to hospitals, but we're trying to shift healthcare to the community and even some of the operations you're talking about can now be down as outpatient. So, I know the topic is hospital productivity, but how is that going to shift if care moves into the community? And to the question about Medicare not being a big factor because there are commercial payers who are willing to pay in Fort Wayne. With the aging population, is that dimension going to change?

MS. SHEINER: Yeah, I'm not sure about how to think about this. So, I think there has been -- since 30 years this shift away from the hospitals. One of the reasons actually that Medicare's doing fine is that all this excess capacity in hospitals, and so, it's not so -- so you're less likely to have access problems as a beneficiary. In terms of productivity, so, I think that there's sort of two things, which is again, it's quite possible that we could be a

lot more productive than we are. And our productivity hasn't been that bad. Those are actually not at odds, right. And so, especially with an aging population and fiscal pressures, clearly whenever the systems is not as efficient as it could be that's wasteful and leaving money on the table, but as these budgetary pressures get higher and there's aging that's just going to be more and more compelling. So, looking for ways of shifting care to the community I think is really important. And I'm not an expert on how that happens and sort of the payments rates that you have to make sure that there's incentives to do that. Some of the bundles are really about that, which is like I'm going to pay regardless of where the care is and therefore, you have the incentive to provide care in the best way.

I'm going to go back to something that Chapin said and other people sort have mentioned, which is this idea of not being able to attribute the productivity growth to the hospital is sort of a technical question of whether or not we're doing the measurement right. Because the idea behind it is not to say, oh, life expectance has gone up, hospital spending's gone up but the life expectance is worth it, so we're done. What you really want to do in these studies is to say, for what conditions can I reasonably say the changes in outcomes are because of what the hospital did, right. So, that might be hard, but a least in a framework kind of way that's not -- that's what we need to be doing, right. We don't want to be paying hospitals for things they haven't done. So, I don't know how much that answers your question, but --

MR. GINSBURG: Thanks. Well, I think this is a good time to transition to the next panel. I want to thank the panelists for a great job they did.

(Applause)

(Recess)

MS. SHEINER: Okay. So for this next session, what we're going to do is we have four panelists. And they're going to have seven or eight minutes to give their take on these questions. And then we'll have a discussion and hopefully the panels will interact with each other. And I'm sure we'll have comments on each other. And then we'll be off to the

audience. So we're going to start with Paul Spitalnic, he's the actuary from Medicare/Medicaid Services.

MR. SPITALNIC: Thanks, Miss. Thanks for having me. It is really a challenge to follow such a group of distinguished economists. Especially for an actuary. A humble actuary. Basically every note I have already written has already been said in one degree or another. So I'm going to try to frame it in a little different way. And hopefully just introduce a little different take on some of these topics.

As has been mentioned, you know, looking at Medicare payment policy, fee for service payment rates are based on non-physician -- most non-physician rates are updated by the underlying cost index of providing those services less this economy-wide non-form private business multi-factor productivity adjustment.

And the question that's been raised ever since this has been adopted in the new Affordable Care Act is, does this call into question the long-term adequacy of those payment rates for the Medicare program? And what are the implications of those payment rates? So the key part of the fee for service rates is that these are not quality adjusted. These are basically on a fee for service basis. So the more units that are provided, the more revenue generally that's provided to the providers.

You know, some services and some demonstrations might have some quality component to them, that might build some tilt in the amounts of the revenue. But largely speaking, the fee for service program is a more units provided the higher the revenue that goes to providers. There, you know, some examples, penalties for readmissions is an example of the recent policy that kind of does put more of a quality piece to it. But generally we're talking about the tilt. And so the fee for service incentives truly are to provide more services. That's the underlying. But that is what will lead to additional revenue for these providers.

And so most of the incentives in this fee for service program, you know, tend to be not directly related to, am I providing better care, but am I providing more care.

And the question that I continually struggle with -- and I'm looking forward to hearing responses from the economists on the panel and otherwise -- is that, if providers can be productive? And then I think, you know, the evidence that we've seen is very compelling in terms of are we getting value out of what I'll call the lack of unadjusted productivity? Are we getting value there? I think the answer is yes. We're getting better outcomes, we're getting, you know, on this quality adjusted basis.

But if these providers can provide productivity on that basis, how come they're not as good or so good or good at all or even positive, with respect to how they're revenues are actually being generated. Why are they not able to actually maximize their revenue? You know, or use this productivity as a means by which to maximize their revenue? So I'm looking forward to seeing all these writings.

I'm looking forward to hearing the answer in a little while. So in terms of just general data, over the last ten years where we've had very low on the economy-wide productivity, it has averaged about, you know, 0.5 percent. Most health providers have averaged between 0 or 0.5 percent. So there's a relatively small gap over the last decade.

During this last decade, we've seen a significant divergence between Medicare payment rates and private payment rates. I know we're not allowed to talk about it, but cost shifting doesn't happen in this room, so there's a lot of different terms for it, but I see a wedge. And whatever it is, the wedge has gotten worse since there's been at least some degree of clamping down on the Medicare payment rates. Looking towards the long run, and the Medicare Board of Trustee, looking at the long run, not many people do 75-year cost projections. The expectation for the long run economy by productivity is 1 percent. The expectation that was illustrated earlier is 0.4 percent within the health sector, 0.6 percent adds up a lot over 75 years.

In fact, if you were to account for that roughly, that 0.6 percent difference, and the Medicare report does, the Washington alternative is a scenario of where, you know, what if we assume the productivity payment reductions weren't at the 1 percent level but at

the 0.4 percent level, and a couple of other different pieces. It adds up a lot.

Under current law, the expectation is that Medicare payments at the end of the 75 years would get to 6.5 percent of GDP. Under the Washington alternative, where just that 0.6 percent is changed in a couple of other factors. The difference is 9 percent. So it is a huge impact. Especially looking over the longer term.

If we look at margins, and yes, this has gotten a lot of attention. It's been alluded to earlier. Medicare margins have been bad and are getting worse. So since 2010 hospital margins have fallen from, on average, -5 percent. It is now closer to -10 percent. And this is at the same time when hospital margins for non-Medicare -- on the private side -- they're at all time highs.

Again, not talking caution, grifting, whatever the current term is. There's something happening here, where there are shifts occurring.

The question becomes what happens in the long run with respect to these payment rates. Especially when the economy-wide productivity actually comes back from, you know, these historic low levels of the recent decade. And when these productivity adjustments will actually start taking a bite within the Medicare program. So with that, I'll turn it over.

MS. SHEINER: All right, thank you. Let us turn to Jim Mathews from MedPAC. Yes. You've got it.

MR. MATHEWS: All right, great, thank you. And I'm sorry about the technological glitch, there. So I'm going to take a little bit of a different tack here with a couple of comments here. And shift the discussion a little bit from productivity to efficiency in the hospital sector. Which is the policy aspect that the commission has been dealing with, not only in the hospital sector over the last six, seven, eight years or so, but also starting to apply this concept in our evaluation of the adequacy of Medicare payments across a number of different provider types.

And here, I'm going to be talking about a combination of relatively high-

quality and relatively low-cost. Which does implicate the concept of productivity, and especially change over time. But I'm going to be talking about a very specific aspect of productivity here.

I'm also going to then shift and talk a little bit about incentives that the Medicare has been able to apply and provider payment generally and hospital payment specifically. In a way that haven't historically been applied in the private sector. And talk a little bit about why it is incumbent upon Medicare as a public payer to apply this sort of financial pressure.

And then I'll take, you know, 30 seconds at the end of my presentation and talk about the impact over time of the Medicare program applying financial pressure in the way that it has. And implicit in my comments here are the notion that, again, as a public payer financed by taxpayers and beneficiaries, it is indeed incumbent upon the Medicare program to apply financial pressure to providers.

And we think that this is something that private payers, commercial payers should be doing more of. And it keys off something that Chapin said earlier, that providers costs will basically follow their payments. The more you pay them, the more costs they will incur. And we don't think that's necessarily a good thing, and we believe that the commercial sector should be doing more to impose financial pressure on providers -- if the overall societal concern here is the unsustainability of cost growth in the health care sector as a whole.

So a couple of commenters here today have mentioned MedPACs payment update recommendations with respect to hospitals. We use a standard framework in making out recommendations. We look at beneficiary access to care, provider access capital, quality of care, and of course, the infamous Medicare margin.

By and large, most of our indicators of Medicare payment adequacy for the hospital sector are good. With the exception of hospital margins. Which as Paul said, have been declining steadily over time and are currently at about -10, and we project a margin of

about -11 percent for 2019.

However, there is a subset of providers that we've determined to be relatively efficient. They are not in the worst performing third of hospitals on quality, and they're not in the highest cost third of hospitals. And so, when we look at the subset of efficient providers, we see that their margin is more like -2 percent. And so, their performance is better under Medicare than hospitals as a whole. And so we focus our assessment of Medicare payment adequacy on this subset.

So again, these are providers that do relatively well on cost and quality measures, and their performance has to be consistent over a prior three-year period when we make these determinations. The metrics that we use to determine efficiency are mortality rates, readmission rates, and standardized costs per case.

When we compare efficient providers, efficient hospitals to others, we have a relatively small group of 14 percent in 2017. And again, this is using a fairly generous definition of efficiency. You're not in highest third of costs, you're not in the lowest third of quality. So, you know, we're getting about 14, 15 percent of the hospital population in the efficient group.

But in that group, their performance is relatively good. Their mortality rate is substantially lower than the average hospitals. Readmissions is substantially lower. And their standardized costs are lower. So it is possible to achieve a relatively high level of efficiency for some hospitals, even under Medicare payment rates.

However, as Paul mentioned, there is a concern about a declining trend in Medicare margin over time. In here, you can see that the margin for all other hospitals is currently about -9, -10 in the last couple of years.

Until 2015, the efficient for a hospital had been able to stay in the black under Medicare. They went negative last year for the first time at -1, and now are at -2. So MedPAC made a recommendation this year for the hospital update that would still apply financial pressure to all hospitals in the form of a lower across the board update. But would

focus more money, and again, more dollars than warranted under current law to the most efficient providers.

I'm going to switch gears now and talk about incentives. And again here, the incentives are something that Medicare has been applying in a way that historically commercial payers have not. And the exemplar is the readmissions reduction program.

Last year we did a comprehensive evaluation of the HRRP, and we determined it's been a success in getting hospitals to reduce their rate of readmissions, without any concurrent increase in patient mortality. And their efforts have saved the Medicare program about two billion dollars in the most recent year that we examined.

So incentives are important. Providers do indeed respond to payment incentives. And again, it is incumbent upon Medicare as a public payer to provide these incentives.

Medicare has done this throughout its fee for service administered pricing systems over the last decade or so. And here, you can see the aggregate impacts of that spending -- where you look at Medicare per capita cost growth over the last ten years represented by the dotted yellow line. And it's roughly half of corresponding premium growth for HMOs and PPOs in the commercial sector. So by applying this kind of financial pressure and the incentives to get providers to do what you want to do, you can indeed influence overall spending and cost trajectories. So with that, I'm done.

MR. WHITE: Let me talk a little bit about public policies. So what are the policy implications, the policy questions that we're struggling with.

I think the first is, if we take some steps to reign in the prices that commercial health plans are paying to hospitals, will that result in hospitals becoming more efficient? Right? If you squeeze that, you know, the high price discriminated against payer, and the prices their paying, and you squeeze hospitals revenues, are hospitals going to move in the desired direction on the production frontier?

That's an open question. And I don't think we have a great sense of what

happens when you tighten the spigot on a hospital's revenues and what happens to their quality and are they still doing the things we want them to do in returning patients to the community? I don't think we really know the answer to that. But that it is at the top of my list of research questions to dig into.

I think MedPACs result on there are these efficient hospitals out there, says it's not off the table that you can constrain revenues and hospitals can still perform good, you know, provide high quality care. But the question is, whether hospitals will naturally move in that direction if you constrain their revenues.

The second policy question that comes to my mind is the ACA productivity adjustments. I love that we're on a panel where we're talking about the ACA and we're focusing on the productivity adjustments. Because that, if people focus on the coverage expansions in the ACA and on ACOs -- if you look at where the money is in the ACA, it's all in the productivity adjustments. That paid for a huge chunk of the coverage expansions in the ACA.

Okay, the question looking forward is, is it feasible for Medicare to continue to apply these productivity adjustments going forward. And that relates to the question of whether hospitals are at the efficient frontier. And if we keep cranking down their Medicare reimbursements, are they going to have to start throwing overboard activities that are really important clinically. I don't think we really know the answer to that.

The trustees tell us that the Medicare Trust Fund is going to go insolvent in a finite number of years. You know, in the scarily near future. And at the same time, OACT is telling us that the productivity adjustments are unrealistic, that hospitals aren't going to be able to keep up, and the gap between private and Medicare payments is going to grow over time.

But how do we square those two facts? If Medicare is going broke and Medicare needs to pay more to keep up with hospital costs, well there's only one solution to that, which is massive tax increases to pay more into the Medicare program, so they can pay

hospitals more. I don't think that's really on the table. And I want to know, is it really true that it's unrealistic, impossible for hospitals to crank up their productivity growth to keep up with the productivity adjustments. So that was the ACA policy question. Do we maintain the productivity adjustments?

I also want to point out that there's a legal case proceeding through the courts challenging the Affordable Care Act. And it's possible that the courts could determine that the entire Affordable Care Act should be struck down. The productivity adjustments would go away as part of that. But that's kind of making a policy decision to cancel the productivity adjustments but by default -- kind of stumbling into it out of kind of a broader anti-Obama Care motivation.

I think the biggest public policy question in my mind though is, when we're talking about Medicare for all or public options, what's the right level for those plans to be paying hospitals and other providers? And is it more like commercial plans and what they're paying today? Is it more like what Medicare pays today? Or is it somewhere in between?

I also want to put a peg in the question of when you're talking about Medicare for all, and when you're talking about public options -- maybe State-run public options or a Federal public option -- how are they setting their provider payment rates? And are they setting their provider payment rates the way commercial payers do today? Or are they setting it the way Medicare does today? And this is a governance issue.

In the Medicare Part A Trust Fund we have a fixed budget paid by taxes. Very clear, transparent, obvious taxes. Every payroll stub you get, it shows how much is going into the party trust fund. And we have MedPAC, we have CBO keeping track on exactly how Medicare's paying. And that governance structure has led to the Medicare Part A program being pretty aggressive in constraining growth in payment rates.

And my question, I don't see it addressed or even really nibbled at when people are talking about Medicare for all and about these public options is, do we want Medicare for all that people are talking about, and these public option plans. Do we want it

to be setting prices the way the Part A Trust Fund does? Which is pretty aggressive on putting the brakes on price growth and revenue growth. Or do we want it to be more freewheeling, like in the commercial sector.

And I think that's the long run question about how these Medicare for all and public option plans would play out. And I think a lot of it comes back to this question of, are hospitals at the efficient frontier? And my big picture take is, no. Clearly not in the U.S. And I don't find it satisfying to look at historical trends within the U.S. Because we've had just one set of public policies in place. What I find really informative is comparing hospitals in the U.S. with hospitals in other countries. There you get a richer set of information about the production possible frontier. And Gerry Anderson (sic) did a beautiful study comparing how much Johns Hopkins Hospital gets paid for a heart valve replacement versus KO University Hospital in Japan. Johns Hopkins gets, you know, \$55,000. KO University gets \$40,000. How do they get by with that much less in revenue, and can the hospitals in the U.S. follow suite, and how do we help them get there, closer to that production frontier?

MS. SHEINER: Thank you.

MR. ALTMAN: Yes. Well, I'm not going to use my slides for a couple of reasons. First of all, Paul, I want to thank you for letting me come. I look back and this is one of the most productive discussions I've been part of in a very long time. I really want to thank all the speakers who've come before me. So that's the positive statement.

The negative statements, I realize I'm in Washington now. I have tremendous respect for those of you who work in Washington, and particularly MedPAC, having chaired ProPac for 13 years. But I have to tell you, you are increasingly talking about a world that doesn't exist from the world I see. I totally believe, and you're absolutely correct, if you want to constrain spending, you have to constrain spending. So the ultimate model that MedPAC and others say, we need to constrain the amount of money that Medicare is paying to constrain the spending on the part of the hospitals. I hate to tell

you, hospitals now are increasingly thinking as Medicare being irrelevant.

If you have two people walk into your -- and one's giving you a dollar and one's giving you three and is willing to give you four -- who are you going to listen to? Why should you worry? You're beginning to understand the world that's out there. If you want to really look at the world, look at the physician's side.

Now, I'm one of the few people in this audience who depends upon Medicare for my health care. I've lost three primary care physicians in four years. The primary care physicians that are left are increasingly giving me six minutes, seven minutes. I think concierge medicine is illegal, immoral, and fattening; and I joined it. Because I needed it. I had no choice. My lifestyle could not -- I can't wait for them to give me six appointments.

Louise, you've got it absolutely right. Those three choices are exactly what is happening. Right now on the hospital side, Medicare is a free rider. I have no idea what kind of health care the hospitals would actually produce if all the money they got -- your comment, Chapin, is absolutely correct -- if only they got Medicare payments, for everybody, I have no idea what kind of health care they would provide. But I don't want to get sick.

And don't tell me what's going on in Europe. We're not Europe. We've had 50 years of this thing. So we need to -- you guys are so smart -- you need to be thinking about this. And with all due respect, can we just bury cost shifting as a term? You've done us a service by creating it. It's so out of sync right now with what's going on. Call it what you want, price discrimination and stuff like that.

We have a delivery system out there that is totally different than it was even in 2000. With that said, let me just end by what we're doing in Massachusetts. I think increasingly we cannot have a payment system where basically you're running three spigots that have nothing to do with each other. Medicaid, Medicare, and private.

We need a system that takes some degree of control over all the spigots if we want to bring about productivity growth, if we want to decide what's a fair thing. How we

do it. And that's why increasing -- I was a Fed. I didn't even know we had States.

When I was in Washington, I thought that people who worked at State's were like people on training wheels. And if you were really good, you were in Washington. I hate to tell you, more and more of the pressure is now at the State level.

I think what we're doing in Massachusetts, we made a decision, they made a decision back in 2012 -- from now on we're going to be concerned about total spending, we're not concerned only about Medicaid spending -- and in fact we're trying to do it.

Six States now, in the last year or two, are moving to total payment systems. Oregon passed it last week. Delaware and New Mexico, Washington State -- you're increasingly moving to the recognition that if you're going to do anything in the public sector, you have to be concerned about the total flow of dollars going into the system.

And so, you're absolutely right in terms -- if you want to control spending, you have to control spending. Medicare no longer has much of an impact because, in fact, it is squeezed so low, and you've allowed the other side. So all I would ask you -- those of you, because you guys are doing wonderful work -- you need to take a much harder look at the current environment and change the models.

Everything you said made sense, but it's the reality of it. And Chapin of all, he just, and the Rand people, just did a wonderful study what's going on. Whether it's Indiana or an on average. 240 percent private over Medicare? So come on, the average is 180 percent?

As I said, the health care industry increasingly is dancing to the tune of where the dollars are. And it makes -- so to talk about somehow Medicare payment policy is going to impact the productivity of the health sector, is a joke. Unless we get them all playing from the same set of sewing machines.

And what we're doing in Massachusetts actually is working. We've already talked about this thing. I mean, when you even look at the, you know, the ACO savings, and the Medicare rightly saying, I'm not seeing those savings. You know, the ACO people keep,

well, if you read the fine, what it would have been. I'm on your side. I think Medicare isn't seeing the kind of savings.

We're just beginning in Massachusetts. We don't have rate regulation. We have benchmarks. We're trying to jawbone the private sector; both the insurer's and the hospitals to live within a growth rate consistent with our income. And in fact it's working. And if you look at it, I've given a couple of -- and I'll just leave with this last slide.

If you look at what's going on in Massachusetts, we went from being not only the most expensive place on the planet, but also the fastest growth rate. We're now the fourth lowest growth rate in terms of total spending in the United States. And as I said, we're doing it without tough rate regulation. We are trying to use the anti-trust. We are squeezing. And we have some pretty powerful providers. Come up to Massachusetts sometime, and you'll see how powerful they are. But in fact, we're making it work. I'm not sure I completely understand why it's working. And I would welcome some of you to come and help us figure that out.

By the reality is, we are looking at total. Medicare is part of that. But Medicare cannot do it alone. And to keep talking about, somehow, you're making the system more efficient by Medicare rates, I'm sorry, that's not the reality out there. They're not listening to you they don't need you.

Now, the people that do need you, when you go to safety-net hospitals and they're on Medicare, and they need you a lot. And they're furious. Because they're getting squeezed. Now, go to the Mass General sometime, and ask them how much they really, really worry about Medicare given the fact that they can essentially force the private sector to pay any rates they want.

So with that I'll stop. And I welcome a thoroughly discussion, as I said. I couldn't be more pleased to be here. Thank you, Paul.

MS. SHEINER: Okay. So thank you all of you. We covered so much territory in that, that's it's a little hard to know where to start. But I'm going to start maybe,

split somewhere between what Chapin was talking about and what Stuart was talking about, which is, if you're thinking about a Medicare for all. Because that's sort of what you're doing in Massachusetts. At rate do you set it.

And then, you know, a lot of these questions already came up before though, how are we relative to Europe? And I think a question I want to ask here is, when we think about differences and what we think about something like Medicare for all, is the expectation, do you think, that we could really improve productivity? Or that we are going to sit on things like wages and compensation? Which isn't productivity. It's just a distribution. Which I think, you know, it's not 100 percent clear what the differences are between Europe and the United States, but certainly payment is part of it.

So what would each of you actually think about how would you set a Medicare for all kinds of prices, and what would be the considerations? I'm just going to let you start.

MR. WHITE: Right. How would you set the price? I don't know what the right price is, but I know that in our current system we have agencies, organizations that are helping guide U.S. And OACT is one, MedPAC is another, CBO is another, CMS is another. And these organizations are putting the cards on the table and helping inform a healthy policy debate. And in Congress, they're roughly trading off tax increases versus provider payment cuts. And for a long time they were going with the tax increases. Lately it's been provider rate cuts. And I don't know if the rates they landed on are the right ones, but it's a healthy policy making environment.

Contrast that with employer sponsored insurance, where employer's -- the HR, the Human Resources folks -- generally don't understand health care. They're relying on brokers, the brokers are in bed with the carriers, the carriers are in bed with hospitals. Nobody knows whether they're paying a fair price. They don't understand how to measure quality. They don't know how to get better quality. That is not a healthy policy making environment in general. I mean, there are glimmers of, you know, useful information being

generated and transmitted, but the governance structures around the Medicare program are very healthy. And I think those governance structures, we need to have them in mind when we talk about Medicare for all and public options.

MR. ALTMAN: Well, we have established what we think is the right way to do it. And I agree with it. Which is over time, start squeezing slowly. And as I said, we've set benchmarks based on what we consider to be our long-term growth and income. And originally it was at 3.6 percent, it's now down to 3.1 percent. And in fact, the system is living.

Now, you know, when I was in Washington, you know, I was the ultimate regulator in 1971. I'm the only person that ever regulated the rates -- full rates -- I had rate regulations at the Federal level in peace time. But I was 35 years old. And I had never been to the hospital since I was born. I didn't give a damn about the health care system. I am now falling apart. I care a lot more about the health care system than I used to.

And the idea that, somehow, we're going to wake up tomorrow morning, that Medicare for all is a joke, because they never talk about what Chapin said. If all of a sudden, we went to Medicare for all and all those private rates went to Medicare rates, we're talking about taking between a half a trillion and three-quarters of a trillion dollars out of the American health care system. I have no idea what the health care system would do with that kind of -- no amount of productivity would ever come close.

So I think what we're doing in Massachusetts -- there is no one right answer to your question. We're trying to slow the growth over time. Because I firmly agree with the MedPAC rule -- you've got to -- forget about waste. If you want to make this system spend less, you have to give it less revenue and force it to deal with it.

But as I said in my criticism, and it's not a criticism of you, you don't have that authority. So that's my view. We need to squeeze on the system. There's no one right number. We've picked the growth in our income. And we're slowing faster than the rest of the country.

MS. SHEINER: Anybody else want, do you want to go ahead?

MR. SPITALNIC: I actually would.

MS. SHEINER: I can't believe you want to talk about this.

MR. SPITALNIC: I actually am not going to answer your question. But I am going to respond to Stuart on this. Just the notion that Medicare is becoming largely irrelevant. When Medicare is four or five of every ten dollars, I think we still get a fair amount of intention, you know, placed on what the Medicare policy --

MR. ALTMAN: Excuse me but (inaudible) --

MR. SPITALNIC: I don't claim to be a regulator, but I know a lot of regulators in my organization. And so the notion that's -- and I probably underestimated or underemphasized -- the notion of what's happening with respect to quality incentives and the demonstrations that are truly trying to reshape the incentives around where those revenues are coming from. From these organizations. From just the service based to the quality based.

And so to the extent that there is at least some degree of transformation that's occurring, it is starting at the CMS level. It's such that we can actually have this discussion over what is the right level of payments and how can we align those incentives to exactly what we are trying to get out of our system. And so at least those conversations are starting to happen. You know, probably not to the speed and perhaps success that others might want to see in terms of actually lowering the levels of health care. But clearly the direction has shifted and is moving in that direction.

MS. SHEINER: (Inaudible).

MR. ROMLEY: Okay. For the record, I am not going to talk about Medicare for all. But I do want to address a couple of comments from Stuart and from Chapin.

First, I do agree completely that to do something about cost growth in this country is going to require a concerted effort across all payers that simply does not exist. And from my perspective, you know, Title 18 is the sand box that I have to play in. So that's what I do.

But I do not disagree with you that it is going to require effort across Medicare, Medicaid, Commercial. And as I said in my comments, you know, Medicare has been attempting to apply fiscal pressure in the form of reduced updates, in the form of value incentive programs, and is trying to move that needle. And in imposing that level of fiscal discipline or fiscal pressure, it has widened the gap between financial performance under Medicare and financial performance on the private side.

But I think that gap is somewhat illusory in that it reflects, you know, a growing cost structure on the provider side that's being fed by extremely generous payments on the commercial side.

SPEAKER: Yes.

MR. ROMLEY: And so I wouldn't say that it is beyond the realm of possibility for providers to control their costs in a more substantial way than they've done in the past, given the right incentives. And one of the bits of evidence that I would point to in making that assessment is, in conjunction with the efficient provider analysis that MedPAC has done over the years, we've also looked at hospitals that are under fiscal pressure. And we define these as a subset of hospitals that have very low private sector margins.

SPEAKER: Yes, yes.

MR. ROMLEY: They have very low net worth. And when we compare those hospitals to another set that are not under financial pressure, we see that the financial pressure hospitals have lower per unit costs and lower cost growth over time, so.

MR. ALTMAN: Couldn't agree more. But you're putting pressure, in some sense, on the wrong hospitals. I mean, in a public policy sense, you're putting all in a safety net. So, we all agree. I think --

MS. SHEINER: Sorry, I have a question. So I want to bring it back to the hospital productivity stuff and the stuff that John did.

Which is I see this tension between this idea that clearly we want to reduce spending and reduce costs, and that putting pressure on hospital reduces costs, it may well

be that the hospitals that are under financial pressure aren't doing some of the things that lead to some of the outcomes that John's picking up.

And, you know, these can be quite difficult and subtle to measure, right? Like getting risk adjustment right is really hard. And sort of knowing the timing of when a cost squeeze might show up in mortality, because it may not be right away. So is there a tension there?

MR. ALTMAN: Yes.

MS. SHEINER: Between --

MR. ALTMAN: That's great. I mean, that's the -- when you look at our safety net hospitals, they're not bringing the technology onboard. You go into those hospitals, they're older and they're seedier and they're cutting costs. I love the study that you raised. And you raised showing that if you really do a good job, we are seeing improvements in productivity, maybe not as much as we could.

But go look into the middle of those hospitals, the ones that you called the ones under fiscal pressure. And compare them. And where do you want to go to get your health care? I'm sorry. I'm not going there.

MS. SHEINER: Hmm. Chapin, did you want to --

MR. WHITE: Yes. There's a really nice study by Yu-Chu Shen and Vivian Wu on the long-term mortality impacts of Medicare rate reductions. And they raised a flag that if you start cranking down the Medicare reimbursement rates, you may see negative impacts on health care outcomes.

Now, I don't have a good sense of the totality of the literature and whether that finding is backed up and whether it holds up over time. But in my mind, the path to go is, first address the egregious overpayment by commercial payers in many contexts.

At the same time, push hospitals to improve quality actively. It's a separate dimension, but if all we're doing is constraining revenues, you may not get the desired outcome. What we want to be doing is pushing simultaneously down on the revenues and

up on the quality. And those are two separate undertakings. But you don't want to just be focusing on the revenue side, you want to be actively pushing them to improve quality. Through things like the readmission reduction program, unnecessary C-sections, and so on.

MS. SHEINER: So a lot more of a shift in the way we pay towards performance based or do we actually know -- so we have examples when we know they work. But how much confidence do we have that we could do a lot more by having sort of marginal incentives?

MR. WHITE: I think that you can get a lot of juice out of measuring outcomes, comparing providers, benchmarking and relying on their professionalism -- their non-profit status, their community-benefit orientation to want to do better.

And it always makes me a little nervous when we say, okay, we have this professional cadre of health-care providers. And the only way they're going to do better is we pay them. Well, that's not necessarily true. But just measuring, you know, figuring out what makes a difference in health care quality and outcomes. Measuring, reporting, job owning, pushing on hospitals, using their professional orientation and the fact that they generally do want to do better.

MS. SHEINER: Okay. Last question from me, and then I'll go to the audience. And this is going to go back to where we sort of started. Which is, so when we think about margins, do we care about the overall margin, do we care about the Medicare margin, do we care about the marginal cost of the Medicare patient? Like, what is it that we should be most worried about? And when would you say, oh, here's a real signal that we better change policy and change course on this productivity adjustment?

MR. ALTMAN: Well, what do you want to do? I mean, there's no question that in the short run on the hospital side, and MedPAC has said it several times, that it still pays the hospital to take on a Medicare patient. But you know what, if we keep doing what we're doing, you're going to see hospitals begin to behave like physicians. I don't know where it is. You're going to see some hospitals, you know, become much more restrictive.

Now, as I said, I hope that never happens. I think we made a commitment to the seniors that that should never happen. And I appreciate the fact that MedPAC is now recommending an increase, because it's getting nervous, as it should.

But we don't know where that rate is. As I said, I think the physician market is a better indicator of the problem that's already being created. Particularly at the primary care level.

MS. SHEINER: Yes, go ahead.

MR. MATHEWS: Can I ask you to say a little bit more about that? Because of a couple of things. When MedPAC assesses the adequacy of Medicare payments to hospitals, margin is one thing that we look at. But we also look, as I said, at access to care, supply of providers, access to capital, and all of those indicators run positive. Even in light of the financial market.

Let me just say one other thing. When you said that if we continue to apply pressure on hospitals, we start to see hospitals morph into more of a physician response. MedPAC also does an annual survey of beneficiaries, and specifically measures their access to care, their timeliness of getting an appointment, their ability to find a new physician when they are looking for one. And consistently, over time, the performance of Medicare, with respect to its beneficiaries accessing physician care, is consistently better than the commercially insured population, age 50 to 64. Even though Medicare is paying physician 75 cents on the dollar relative to average commercial rates. So could you talk a little bit about --

MR. ALTMAN: Yes, I would definitely. I would suggest that we live in a very -- world where we have many populations. So if you go into our major upper middle class cities -- Washington, New York, Boston, Miami, Los Angeles, San Francisco -- and go to the populations that I would call the upper middle class and above, and ask them how easy it is for them to get access to primary care without going to concierge.

You'll see a very different story than the -- sure. You know, I speak to

1000s, not 100s, 1000s of physicians and patients, and increasingly the seniors. And over the last five years each time I do that, I say, how many of you are having trouble getting primary care? And five years ago, one or two hands go up. Now, I'm seeing still maybe 10, 20 percent, it's not the whole population.

You wander around this city, you're all, you know, Federal employees. Particularly husbands and wife's working, or the upper middle class. I'm telling you what happened to me, and I'm a pretty important person in Massachusetts. I lost three primary care physicians. And the last, I said, I give up.

And so, I suggest you may need to take another hard look at that. Because I think you're trying to do the right thing. And on average, it's still not a problem, but if you take subsets of the population that have the means to say, you know, I don't need to deal with this anymore. I want better care; I want more access to care. And their willing to pay for it. And that's what I finally did.

MR. ROMLEY: So I think the question that's been alluded to in just about everyone's talk today is, at what point and how does it manifest? This divergence between private and commercial and Medicare payment rates. At what point does that become a breaking point? And what does that breaking point look like? And what are the ramifications? And what's anybody going to do about it? And I think all of those are largely unknown. I think it's all things that we're all concerned about. And all things that we need to be following extremely closely. Because at some point, privates aren't going to pay more. The Medicare payment rules are not going to change. And the current dynamic is not going to be able to sustain. What's going to happen? I don't think any of us know.

MS. SHEINER: Terrific. Okay. Let's open it to the audience. Wait for the mic. Start, go ahead. Let me get you (inaudible). As I say, we are going to the audience.

MR. MATHEWS: All right. Just two points. One is, when you use the term pressure, I have difficulty relating to the term pressure when it comes to payments for health care in a country where we spend three trillion dollars a year on health care. You know, 40

percent more than any other country in the world.

So I wouldn't call it pressure. I would maybe say we should look at how we spend that three trillion dollars and figure out a better way to spend it to get the health care we want. And that includes looking at things across payer. And if, while we're on that topic of relating one payer to another, you don't need to go to Massachusetts to see that. You can go up the street to the State of Maryland, where I've worked with the folks there. We have all payer rate setting. They're not the same rates for every payer but they're pretty close.

And one of the criticisms that folks in Maryland get is that -- especially from CMS -- is that Maryland, the last number I heard was, Maryland spends two billion dollars a year more in Medicare spending than they would under the national system. But private payers, they are paid 108 percent of costs -- is the number I heard -- compared to 145, 150, 180 percent of costs in the rest of the country.

So it does seem to be working. The one drawback is that the Maryland regulatory system is focused on hospitals. And now, we've put hospitals on a global budget that includes all health care spending in the State. But we only have regulatory authority on hospitals. So we've got to figure out a way to kind of extend that to the rest of the health care system.

MS.SHEINER: (Inaudible), right, over there. Right there. Tell us who you are, please.

MS. STEINBERG: Hi. I'm Caroline Steinberg, James Creek Consulting. I was with the AHA at the time that the ACA negotiated. And the first thing I wanted to say, that there was not an expectation on the part of hospitals, that we were going to improve their productivity.

The expectation was that that this was going to be paid for by increased coverage. And of course, that only really works in the first 10-year -- in the budget window. And nobody, honestly, was really looking outside the budget window.

But then also, I think it's also important to note that the productivity cuts really didn't happen in the way that CBO estimated. First of all, productivity was much lower, and then also, the forecaster went in the direction of hospitals I think all the years so far, except for one. So the hospitals never got a rate cut because of the ACA.

And CMS does not adjust for the forecast there. So this divergence in margins is not because Medicare was excessively constraining costs, because it didn't really happen. It was because something was going on, you know, that costs were growing, one might say indiscriminately, over this period.

And it's also evidence, and generally I agree with Stu, that Medicare is not influencing in hospitals. I mean, what we have is a situation where there is significant consolidation for everybody. Employers have no leverage; Medicare doesn't matter because they can make that up on the private sector.

And I think when you try to look at things at a very global level, it doesn't really get you anywhere. I think where you really have to look, is like the study that RAND did where they looked at the differences in prices from market to market. And even within market, there are huge differences. Like, if I look at my -- I actually have access through my health insurer to the prices that I would pay. And I can look across the hospitals and I can see that, you know, I live in Northern Virginia, very, very consolidated. I have to drive into D.C. to get a better price. And I'm sure that that hospital knows it.

So I mean, we've got to do something about the market. And it's not -- I mean, Medicare can do whatever it wants -- but until we've addressed the pricing power and the pricing differentials in the private sector, we're not going to get anywhere.

MS. SHEINER: I understand.

MR. WHITE: So this question of whether Medicare matters. Medicare matters hugely. But in terms of volume of services, Medicare is maybe 40 plus percent of the output that hospitals produce. Medicaid is maybe 15 percent. And then the commercial, uninsured marketplace, worker's comp, you know, that's the remainder. So Medicare plus

Medicaid are paying for most of what hospitals do in the aggregate. And they're kind of a stable ship. But, you know, kind of boring and stingy, right?

The commercial side is where, you know, all the exciting high prices -- and that's where all the profits come from. So in our study we found commercial is paying 240 percent of Medicare -- if the Medicare margin is minus 10 percent -- so hospitals costs are maybe 110 percent of Medicare. In commercial plans they're paying 240 percent of Medicare, most of commercial payments to hospitals are profits. Right?

So those profits are going to light up the eyesight of the hospital executives and lead them to open more freestanding ERs in suburban, privately insured neighborhoods, and expand their service line offerings that are tailored to the privately insured population. But Medicare and Medicaid together are still paying for more of what hospitals do. And Medicare matters.

On the question, which ones going to break? Is Medicare going to come up? Or is commercial going to come down? I think it comes back to Stu's point; our health care system is not under resourced. That's an understatement, right? The system is not under resourced. And who's going to break? I think commercial plans are going to break. They're going to be the ones to break.

MR. ALTMAN: I disagree with you.

MR. WHITE: Yes?

MR. ALTMAN: I really -- and you've done some really good research. So what I would suggest you do, rather than make a global statement like that, go to Ft. Wayne, go into the middle of Indiana. Go into those hospitals and say to them, how many of you are really aggressively doing an ACO where 80 to 90 percent of your patients are on fee for service?

I talk to these hospitals all the time. They'll say, oh, well wait, you know what, mañana. I'll do it tomorrow. When the private sector will go, I don't know what you're talking about. No question. Of course Medicare. I was just pushing your buttons.

But you're increasing less relevant under Medicare. Is that a more common statement? This idea of 40 percent, and this idea that all of private money is profits doesn't make any sense. That's what's funding a lot of this technology, the higher salaries -- if you call all of that profits. So the idea that, sure, Medicare is important. It's critically important.

But what we did with respect to the DRGs, which is mandatory changed the payment system. None of this -- you keep talking about what you were saying -- the idea that you only play in the ACO is if you're going to win? It's not mandatory. You look at your own numbers, it's in rounding errors in terms of the savings.

So unless and until we get a combined activity, and it doesn't have to be the same rates like Maryland, it could be a structurally related.

Second, we're playing from the set of incentives. And make it mandatory. This idea that you only play if you win, and the ACOs are trembling, the idea that they might take risk. Oh, my God.

So I think you need a -- I don't disagree with you Chapin -- of course Medicare is important. But it's less important than it was 10 years ago.

AUDIENCE MEMBER: So why don't we measure for value, price, and reward value? And by value, I mean, how to achieve relative spending. If you want to know what a fair price is, you know, Ovey Rinar (sic) used to say, we know all of this I'm sure, the finest health care in the world costs twice as much as the finest health care in the world. And why is that? Because price does not equate with value. Macro Rules (sic), cost/quality -- separate. They're not measured simultaneously. MedPAC doesn't study this.

I mean, we're talking about productivity. We're talking about sustainability. We don't talk about measuring for value. And I could tell you, since you mentioned Alexander's surprise building, Section 303, I'll point you to the exact phrase, the non-profit, non-governmental agency that's supposed to make transparent data, commercial claims data -- "Quality, cost, and," -- guess what they added between the draft and the final version -- "Value".

ICHOMs has been working on this, out of Boston. Michael Porter out of Harvard, for a dozen years. So if we're going to get into productivity, we're have to start thinking seriously about measuring for value. So my question, if I can propose it is, why are we ignoring value?

MS. SHEINER: So I'm just going to add, so I think that's John's paper on productivity was all about thinking about value. And so that whole trying to measure productivity in those, you know, ways where I show prices were coming down, was because of the value that people placed on what they got.

Now, the question a little bit is, you know, is the way to get more value to pay for it? Or is the way to get it to measure it, to compare, to jawbone? You know, how much more should our, like, would a system that really was just paying for value more than what we have now make a huge amount of difference? I don't know. Does anybody have a view or response?

SPEAKER: I always get apprehensive when we're talking about value. Because the value based to whom, based on what measure. And that opens up a very large debate. And so when we are trying to estimate what is the cost of a particular provision, without actually getting detailed specifications as to what exactly are you measuring and what are the different incentives associated with it, value can often be in the eye of the beholder.

MS. SHEINER: Anybody else? Questions?

MS. STEINBERG: Yes, it's there, up front.

MS. SHEINER: Just tell us who you are, please.

MR. LEWIS: Hi. My name is Lewis. Quick question. You had mentioned that they were 14 percent, about 15 percent of hospitals were consider efficient, which had a relatively low or less negative margin. I guess my question is, was there anything specific that tied those hospitals together? Whether a geographic distribution, socioeconomic settings, academic versus community?

MR. ALTMAN: The only fact, and I'm sorry, the only fact that comes to mind in terms of characterizing our relatively efficient group, is that for profits are somewhat under-represented in the efficient group. Other than that, Jeff, I don't know if you want to?

SPEAKER: Yes. That's about the only one. The other one is they tend to be large. Sure.

MS. SHEINER: Thank you.

SPEAKER: They tend to be larger. And part of that is the quality metrics -- especially mortality -- tends to be a little better at larger hospitals. The other factor is we require some stability of performance over a number of years. And it's just harder for smaller hospitals to get that stability of performance.

MS. SHEINER: So I had a question about that before. I'm going to follow-up. Which is, so if you're saying the payment policy should be based on this efficient hospital, and you know, a small hospital can't get there, then are you not just penalizing the patients who live in areas where hospitals, you know, it's a small town, or maybe it's just not going to change overnight. Why would you base the payment on that? Unless you thought your payment was going to drive the efficiency to that level?

SPEAKER: You know, at some point, we're going to have to make a tough decision on what you said. Which is what's the product that we're buying? And, you know, things like mortality and even morbidity become only part of the equation. I've been in the hospital several times. And I wanted good food, I wanted easy -- listen if I go to the Ritz-Carlton, I want my hospital to look like the Ritz-Carlton. You know, I went to hospitals in other countries to look around. I don't want to go there. Because I view quality in a very different sense. And not me -- I think most patients do. And so when we talk about buying -- the reason why I like the slides, when we talk about buying a product that is different, and if all of a sudden we didn't have that product and it began to look like the products in Europe, even though the mortality rates don't change. Hey, listen, I grew up with M*A*S*H. They saved a lot of people. I wouldn't want to get my health care the way the M*A*S*H units were

set up.

So I do think that when you talk about productivity, you have to talk about it in the context of the -- and that's the reason why I like the new slides. Which have those positive statements, when you take a broader view, and I said we even need to take a broader view.

MS. SHEINER: Okay. Did you want to respond or? You don't have to. Anybody else?

MS. STEINBERG: In the back there.

MS. SHEINER: Okay. Tell us who you are and where you're from.

MR. GAGLIANO: Louis Gagliano and I'm Coalition to Transform Advanced Care. If we've learned anything in health care in this system, it is that incentives and pricing does make a difference. And I go back to the implication and the application of the Macro Rules, both on, as you said, readmissions and, as importantly, infection rates in hospitals. And if you look at what's happened because of those incentives, or disincentives in the case of the clawbacks that occur. It did change how hospitals operated. And when those rules got popped, they had to react to, how do I do surgery in a more effective way so that post-infection rates don't occur. So I think that that is one issue.

The other issue is, I think, CMS and Medicare has got to change its philosophy on pricing. And the question is how do we build quality and measurements in it? Not just looking how to wrench down pricing. Because that results in nothing, as you've learned in Massachusetts. So we need to be more global in terms of embracing concepts of how pricing creates the right incentives to drive care in hospitals that does result in better patient care and outcomes. Because better patient care and outcomes drives down cost.

MS. SHEINER: Okay. Anybody else? Go ahead.

MR. SPITALNIC: One quick thing on pricing and incentives. With commercial payers paying 240 percent of Medicare, it's a huge incentive for hospitals just to do more of whatever the privately insured patients get. And give an EKG to every patient

that comes in the ER. Build new free-standing ERs in these suburban privately insured areas. And so, there's huge attention and research and thought going into Medicare payment policy and steering providers in the right direction.

On the commercial side, it's not, I mean, there's like ACO activity and paper performance and so on. There's also just gross over reimbursement of anything a hospital does to a privately insured patient. And that skews incentives not in the way you want. So I think that Medicare can do more to boost more of what we want, but I think it's also important just to kind of ease off the profit incentives to do more of anything to a privately insured patient.

MS. SHEINER: Okay. Well, we are out of time. Please join me in thanking our panel. Thank you. And please pick-up your cups and do the people a favor if you can and take your cups out with you. And thank you all for being here. Sure, I'll fix the error.

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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.

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