MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
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9:49 a.m.

COMMISSIONERS PRESENT:

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MR. HACKBARTH: Good morning everyone. This morning we have two sessions. The first our final discussion of the SGR report and then one session on payment adequacy and update recommendations on hospitals.

So on SGR, Kevin, Dana, who's leading the way?

MS. KELLEY: Good morning.

This will be our final presentation on MedPAC's mandated report to the Congress on the SGR. Today, Kevin and I will summarize the main points to be covered in the report.

What we need from you is assistance in identifying points that we have omitted or parts of the report that are unclear or need to be beefed up our toned down. We'll take your written comments, along with today's discussion, and revise the draft for publication on March 1st.

Before I begin, I want to acknowledge the staff members who aren't up here today but whose efforts have been integral to this work: Niall Brennan, Cristina Boccuti, David Glass, Scott Harrison, Megan Moore, and Jennifer Podulka.

The Deficit Reduction Act of 2005 requires that we
report on mechanisms that could be used in place of the

current SGR system for updating physician fees. The report

must do several things: identify and examine alternative

methods for assessing volume growth; review options to

control the volume of physician services while maintaining

beneficiary access; examine the potential for volume

controls using five alternative types of target tools, group

practice, hospital medical staff, type of service,

geographic area, and physician outliers, and consider the

administrative feasibility of each; and finally, identify

the appropriate level of discretion for the Secretary of

Health and Human Services to change payment rates or take

other steps to affect physician behavior.

In addition to the analyses of the five mandated

alternatives, our report will provide background information

on the SGR system and a detailed discussion of MedPAC's

vision for improving the value of the services Medicare pays

for. The report will also lay out issues that cut across

all the mandated alternatives and will explore additional

options for addressing expenditure growth.

Our report will begin with an introduction

outlining the key issues. First, since 2000 Medicare
spending for physician services has climbed to 9.4 percent per year. Spending has grown largely due to increases in volume, the number of services furnished, and the complexity or intensity of those services.

Medicare's fee-for-service method of paying for physician care itself contributes to volume growth, and some observers have hypothesized that physician volume growth is spurred by new technology, demographic changes and shifts in site of service. Change in disease burden may also play a role. But analyses by MedPAC and others have found that much of the rise in volume is unexplained. Moreover, it's difficult to determine whether volume growth is improving the health and well-being of Medicare beneficiaries.

Further, rapid expenditure growth directly affects beneficiaries' out-of-pocket costs through higher Part B and supplemental insurance premiums and copayments. And just as important, rapid expenditure growth increases the burden on the American taxpayer.

At the same time, it's well established that many Medicare beneficiaries do not receive services that are known to improve health and perhaps reduce the subsequent need for more expensive services like hospital admissions.
The challenge for Medicare, as well as for private purchasers, is to encourage the optimal mix of services. On its own, a formulaic approach is unlikely to accomplish this goal.

Under current law, the Congress has only one expenditure control lever, the Medicare physician payment rate. That rate is calculated each year under the SGR system. Expenditure growth has been so high in recent years that the SGR system has calculated substantial reductions in the physician payment rate, but the Congress has repeatedly overridden the SGR system and prevented those reductions. As a result, the cumulative SGR formula calculates even larger payment cuts the following year and results in a longer period of negative updates.

The Medicare Trustees project that the SGR would dictate fee cuts of 5 percent per year for a long period into the future, cuts that the Trustees consider unrealistic because the Congress is unlikely to implement them. But the budget baseline includes the large fee cuts, making it costly in terms of budget scoring even to maintain fees at their current level.

The fundamental question for the Congress is
whether it wants an overall limit on Medicare spending for
physician services. Some argue that if properly designed
and allowed to function, expenditure limits can effectively
control volume and expenditure growth. Others believe the
value of an expenditure limit lies in the fact that it
forces annual attention to the issue of Medicare spending
which, if allowed to increase unchecked, will require
reduced spending elsewhere in the budget, higher taxes, or
larger deficits.

Others are opposed to formulaic approaches,
contending that they cannot distinguish between good and bad
care, provide little incentive for individual providers to
control volume, and penalize providers who use health
resources conservatively.

If the Congress determines that expenditure limits
are necessary, the Commission has concluded that such limits
should not be borne solely by physicians. Rather, they
should ultimately be applied to all providers. This will
encourage providers of all types to work together to keep
costs as low as possible while increasing quality.

Congress may also wish to apply whatever limits
are used on a regional basis. Risk-adjusted Medicare
spending per beneficiary varies at the state level and even more when measured at the level of hospital referral areas. Moreover, high spending areas often have lower, not higher, quality of care.

The Commission recognizes the desire for control over rapid increases in Medicare spending but wise stewardship of the program goes beyond controlling its cost. Regardless of whether Congress explicitly limits expenditure growth, it's imperative that Medicare increase the accuracy of its payments and create new payment policies that reward providers for efficiency, quality and coordination of care across sites.

These improvements will require a much larger investment in CMS, both dollars and administrative flexibility. CMS will need to develop, update and improve information systems and quality and resource use measures, as well as contract for specialized services. In the long run, failure to invest in CMS will result in higher program costs and lower quality of care.

Our report will then consider alternatives to the SGR. As required, we assessed the pros and cons of the five alternatives mandated by Congress and then we also
considered some other options.

As you'll recall from previous presentations, the geographic alternative would apply an SGR to sub-national geographic areas, setting different fee update amounts by region, acknowledges the fact that regional practice patterns vary and contribute differentially to overall volume and volume growth. Use of different regional updates could help reduce geographic variation over time. However, it's not clear what the optimum geographic unit would be.

Choosing the unit involves tradeoffs between physician accountability, year-to-year volatility, and administrative feasibility. Using smaller units, such as counties, would create target pools that might increase physician accountability, for example, but would increase year-to-year volatility and be difficult to administer.

Using different regional updates would not entirely addressing the inequities of the current system. For example, a physician who practices conservatively in a high-volume region would still be penalized. Using different regional updates could also create wide disparities in payment rates across areas. Border crossing by physicians and by beneficiaries would also be an issue.
A type of service SGR would set expenditure targets for different types of services, as was done by the VPS system. This alternative recognizes the fact that volume growth differs by type of service. Using service-specific targets could allow policymakers to shift resources from types of services that are considered to be of lesser value to those that are considered to be of greater value. This alternative could also be used to try to boost payments for physicians providing primary care.

But service-specific targets present a number of difficulties. One is that such targets ultimately undermine the integrity of the RBRVS. Under service specific targets, payments would vary not only because of differences in RVUs but because of differences in conversion factors. In addition, because setting service-specific targets requires choices among services, using such targets could put policymakers in the position of determining what represents good care. That would likely involve ongoing and contentious debate.

Congress also asked MedPAC to analyze an alternative to the SGR that might adjust payment based on physicians participation in group practices, since studies
suggest that physicians in multispecialty group practices
may be more likely to use care management processes and
information technology and to have lower overall resource
use.

But considering the low share of physicians in
multispecialty groups and that not all group practices
engage in activities that improve quality and manage
resource use, payment policies that focus solely on group
status may not effectively elicit desired behavior.

Further, using separate targets for groups and non-group
physicians would be inequitable since efficient physicians
in smaller or solo practices would be ineligible for the
presumably higher group payment updates. In addition, rural
physicians might have few, if any, opportunities to join
group practices.

Establishing payment incentives for performing
specific activities associated with better care and lower
resource use would probably be more effective than using
separate targets based on group practice status.

A hospital medical staff SGR alternative would use
Medicare claims to define hospital medical staffs by
assigning physicians and beneficiaries to the hospitals they
use most. Using these extended hospital medical groups could better align incentives to control expenditures. Although the size of the groups would vary substantially, each of them would be much smaller than the current national pool. Individual physicians could therefore more readily see a link between their own actions and their group meeting its target. These groups would also increase incentives for physicians to monitor the behavior of their peers. Over time this alternative could increase care coordination and reduce expenditures.

But there are significant barriers to this alternative. Some argue that hospital medical staffs are not currently functioning well and are unlikely vehicles for change. Physicians may resist being assigned by Medicare to an entity to which they may feel little or no affinity. Physicians who rarely refer patients for hospital care may be particularly resistant. There would also be legal obstacles to this option.

Finally, Congress asked MedPAC to look at outliers as an option for reforming the SGR system. An outlier policy could be used to identify physicians with very high resource use relative to their peers. CMS could first
provide confidential feedback to physicians and then, once
greater experience and confidence in outlier measurement
tools were gained, Medicare could use the results for more
aggressive interventions such as public reporting, pay for
performance, or differential updates based on outlier
status.

The major advantage of this option is that it
would treat those physicians with high relative resource use
differently from other physicians. It would promote
individual accountability and would enable physicians to
more readily see a link between their actions and their
payment.

However, there are a number of issues that would
need to be resolved. Implementation of an outlier system
based on episode groupers may prove difficult if physicians
cannot be convinced of the validity of episode grouping
tools. There would also likely be considerable controversy
around initial physician scores, as some physicians realized
that their practice patterns were not in line with those of
their peers.

In addition to the mandated alternatives we
considered a few others. First, we looked at using
specialty-specific expenditure targets. Under such a system, specialty groups could be a source of peer influence that could induce behavior change. Such a system would also create incentives for specialty groups to promote efficiency and develop standards for quality and appropriateness.

However, a major obstacle to such a system is that physicians self-designate their specialty. Without administrative controls, a specialty-specific target system could lead to physicians changing their specialty to avoid reductions in payment rates or to seek higher payment rates. Specialty-specific targets could also undermine efforts to promote more collaboration among physicians of different specialties.

We also considered a reconfiguration of the current national target. For example, the current system could be changed to eliminate the cumulative aspects of the spending targets.

Another option would be to implement an additional allowance corridor around the allowed spending target line. Both these options would result in more favorable updates but, of course, would increase total expenditures.

I'll now turn it over to Kevin, who will discuss
an additional alternative to expenditure control.

DR. HAYES: We return now to the question of whether to retain an expenditure target for physicians. The draft report discusses two paths that Congress could follow in answering this question.

Pathway number one would be to repeal the SGR and not replace it with a new expenditure target. Instead of an expenditure target, the Congress could accelerate development and adoption of new approaches for improving value in the physician payment system.

These new approaches are discussed in chapter five of the draft report. They include linking payment to quality, encouraging coordination of care and measuring resource use coupled with providing feedback.

The alternative to path one, path two, would retain an expenditure target but it would differ from the current SGR in three important ways: one, a new system of targets would apply to all of Medicare. Two, the targets could be applied geographically. Three, providers could be given an array of options for sharing in gains resulting from their improved efficiency.

Otherwise, pathway two would include the
approaches for improving value that would be in pathway one, namely the linking payment to quality and so on.

If the Congress follows path two and retains a target, the draft report discusses a rationale which is that it maintains pressure for continual improvement. For policymakers, it is pressure to improve payment systems. For providers, it is pressure to improve efficiency. And if there is a target the report discusses the idea of expanding it to encompass all providers, not just physicians.

Under path two, a target or system of targets would apply on a geographic basis. This would respond to the findings that Medicare spending varies widely across the country and that quality does not seem to increase with higher expenditures. By some measures, it may be lower as spending goes up.

Within this geographic framework, path two could accommodate alternative groupings of providers: hospital medical staffs, integrated delivery systems, multispecialty physician groups, and so on, to bring incentives closer to those providers.

Even if there is a target, Commissioners have discussed the importance of other reforms. These would
include increasing the accuracy of payments under existing payment systems. For example, the Commission has recommended ways to improve the accuracy of the physician fee schedule by improving the review of relative values for physician work.

Pathway two would also include rewarding providers for efficiency, quality and coordination across sites of care. In the draft report we site pay for performance for quality as an example of a way to provide such rewards.

The complexity of this second path argues for a phased approach to implementation. At the December meeting we went over the phases in some detail. To briefly recap, phase one could include adjusting the current expenditure target. For example, one option is to make the target non-cumulative instead of cumulative as it is now. In phase one there could also be rewards or penalties for physicians based on their individual performance on quality measures.

Phase two could start by differentiating payments geographically to reward or penalize physicians and potentially other Part B providers such as hospital outpatient departments.

The expenditure target could be expanded to
include all of Medicare. In phase two, physicians could receive confidential feedback on their resource use. Also there could be public reporting on the performance of accountable care organizations. These are the organizations mentioned earlier, multispecialty group practices, integrated delivery systems and so on.

In the later phases, payments could be adjusted for all providers, depending on whether spending targets are achieved. These could be targets inclusive of all Medicare services.

There could also be opportunities for providers to share in savings. Concurrent with the phases, payment systems reforms could be underway. These could include bundling, gainsharing, and other policies.

We conclude with a few points on the administrative burden for CMS. For both path one and path two the draft report reiterates the importance of increasing substantially the investment in CMS.

For the payment system reforms contemplated under both pathways, there has been some progress already. CMS has a number of efforts underway right now, including the physician group practice demonstration and the physician
voluntary reporting program. In addition, the Agency has taken steps to improve the accuracy of existing payment systems, including the one for physician services as well as those for inpatient hospital care and post-acute providers. The report discusses the importance of accelerating the pace of such improvements.

CMS would bear a further administrative burden if the Congress adopts path two and CMS must then implement the four phases.

For all of this, a way to ensure an investment in CMS is with dedicated resources. Previous reforms have had a large impact on resources. Two recent examples, in the Medicare Modernization Act the Congress made available to CMS and the Social Security Administration $1.5 billion to administer the new drug benefit.

In the Tax Relief and Health Care Act, passed just last month, the Congress made available $60 million for fiscal years 2007 through 2009. This is to implement the Act's provisions for physician payment and quality improvement programs. This amount is separate from a physician assistance and quality initiative fund established for 2008.
That's all we have. That's all of our presentation. We look forward to your comments on the draft report.

MR. HACKBARTH: If I could, I'd like to just add a few comments to what Dana and Kevin presented, saying much of the same thing but in my own words.

I think through our deliberations we've reached a couple conclusions on which there is broad agreement. One of those is that expenditure targets like the SGR do not create appropriate incentives for providers to improve care, to improve efficiency, defined as lowering cost and increasing quality. They are too far removed from day-to-day practice.

Indeed, the SGR has probably created as many or more perverse incentives than positive incentives when viewed from the perspective of the daily practice of medicine or the provision of health care. An example of that would be through focusing on physician fee constraint alone, encouraging physicians to expand their practice by imaging equipment in order to strive to have an economic basis for their practice that is sustainable.

So expenditure targets, per se, are not going to
move us in the right direction for Medicare. I think there
is broad, even unanimous, agreement on that point.

To change the behavior of health care providers,
whether it's physicians or hospitals or post-acute
providers, there is no alternative but to change the payment
systems at a detailed level that apply to those prospective
groups, improve our ability to measure performance, assess
quality, move towards bundled payments of various types that
create a stronger incentive for reducing resources consumed
in providing appropriate high-quality care. And chapter
five, briefly summarized by Kevin, lists a number of
initiatives that we think are critically important in
getting payment systems right and actually helping to
improve care.

In order to do that work in chapter five, we need
a much larger investment in resources in CMS. We have made
some progress in terms of improving payment systems. We've
got some promising demonstrations underway that CMS has
organized. The problem is that the cycle time for
improvement is dreadfully slow and not at all in keeping
with the urgency of the task facing the Medicare program and
the country. On that point, I think we also have unanimous
agreement among the Commissioners.

Where we don't have unanimous agreement is whether, in addition to doing that sort of work to improve the nitty-gritty of payment policy, an aggregate expenditure target could be a useful supplement. And to be very pointed about it, the goal of such an expenditure target would not be to change the behavior of health care providers but rather to change the behavior of health care policymakers and establishing greater discipline in that policymaking process, including updates for providers. Other things as well, but updates in particular.

And there we have a division of views. We don't have consensus on whether expenditure targets could be a useful complement to the payment reform discussed in chapter five.

I think we do have broad agreement though that if Congress were to elect to retain some sort of expenditure target mechanism that a couple of things need to be addressed. One is that such a mechanism should apply not just to physicians but should apply to all health care providers. Medicare does not just have a physician cost problem but rather a total cost problem.
And second, that in some fashion expenditure targets should be adjusted to reflect the large disparities in Medicare expenditures per beneficiary across the country. Not all areas of the country contribute equally to the expenditure problems that Medicare does have.

I think there is consensus on those two points, that it ought to be broader than just physicians and there ought to be some effort to geographically adjust so that pressure is applied greatest in the areas that contribute most of the cost problem.

That's my summary, a very brief summary, of our discussions. That then leads to the two paths that Kevin and Dana presented, path one being repeal SGR, not impose any new expenditure target, then get on with the work of developing detailed reforms and various payment systems.

Path two would retain an expenditure target, albeit in a modified form, but also focus principally on the changing of payment systems.

So that's my personal summary of where we've been to this point.

DR. CROSSON: Thanks, Glenn. I think I'd have to first start out with congratulations to you and to the
staff. As I was listening to all the staff members who worked on the report, I was trying to figure out who hadn't worked on this particular item actually, which I think is a testament to how complex it is.

And congratulations to you for really leading the synthesis of what is, I think, primarily agreement as you've described, although there are probably some areas of disagreement about exactly how to get to where I think everybody would like to get to.

This is one of the most complex, as you mentioned, items that we've discussed at least in my time on the Commission. It's also, I think, one of the most vital things that we'll discuss because I have the notion in here that somewhere in here is one of the important keys to Medicare's sustainability over time as it relates to both moving towards bringing physicians and hospitals closer together, creating incentives for that, and creating, I think, a different set of payment dynamics than Medicare has right now, many of which don't appear to work very well.

It's also been a difficult discussion because of the contentiousness around the current system of physician update payment and the use of the SGR. The word itself is
sort of now emotionally charged. It's a complex idea because it stands for a lot of different calculations and notions within it. I think that's made it difficult. And it has also made it a bit of a struggle for some of us to try to put words to what I think we think ought to happen.

And as we have these discussions, we kind of realize we're all sort of thinking the same thing but we're using different words in some circumstances.

Having said that, I think what I'd like to say is that I think that the target in the end, to me anyway, the target or the use of targets is in the end going to be less important than the dynamic that is created by the payment system because the target really just addresses the amount that's paid -- the update to the target addresses the amount that's paid for a unit of service. Whereas I think many of us believe that it's the numbers of units of service, at least in some areas of medicine, and in some cases the inappropriate use of services that is technology driven in part, that is one of the major props that we're dealing with.

I do think that in some parts of the report the projection of the number of targets that would be required
in some of the examples may be administratively impossible. So I have less interest or concern about the target as a starting point and what that ought to be than the nature of the dynamic. I think I'll just give an example of what I think might be something that illustrates that. And I'm not saying this is the only way that this could be done.

But least what I have in my mind is something like -- and I don't know whether this means adjusting the SGR, changing the name of it, repealing it, pretending it never existed, or starting over, or whatever.

But starting with some basis for next year's payment that would be either based on reasonable input costs or perhaps, in some circumstances, less than that based upon what we think we can afford as a country, taking that number and perhaps modestly adjusting it regionally. Let's say we ended up with a number of 2 percent as a starting point, and we could arrive at that number by a number of different means.

Maybe that number gets adjusted by one point, broadly geographically based on the fact that we have these broad differences and we'd like to see them change over
But then within those broad geographies, so let's say we have geographies now that are at one and we have some that are at three, that based on utilization -- and utilization could be narrowly defined. It could be just physician utilization. It could be physician and hospital utilization, which is what I would believe is right. It could be for all services or it could be a subset of services.

But it would be some measure of utilization of services, targeted maybe at the most inappropriate areas. But then, within those environments, entities that would be created -- and we list in the report ideas of group practices, accountable organizations which would include physicians and medical staff physicians in hospitals -- would essentially work sort of in competition with each other around that number. And there would be a range around that number of reward or loss based on that. Say you had the one in three I was talking about, you might end up with a 3 percent range on each side. And so you could have within each geography some entities that ended up with a couple of points minus and some that ended up with 4 or 5
percent positive.

The point of this is again that the starting point or the target is less important than the competitive dynamic that's created because over time it becomes in the interests -- relatively quickly I would think, in a few years -- it becomes in the interest of entities to be created to be part of this process and then to learn from each other or learn within their own competitive entities what are the areas of efficiency that can be created, where can quality drive better outcomes as well as lower cost, and the like.

So I think that's just broadly my sense. It's that again I think the focus on targets, particularly at the micro level, may drive an administrative complexity that isn't necessary. The focus on targets in the end is less important than the dynamic that's created by the incentives that could in the end reverse what the problem is, which is on the utilization side. And it's not just a physician problem, as has been mentioned. This is an entire system problem.

DR. SCANLON: I agree with much of what Jay just said, although I think the idea of in trying to create something that's simpler, simplicity is a relative term and
we're still going to be dealing with something that's complex.

I think that the staff did an incredible job in terms of this report, in capturing the difficult situation that we're dealing with. Your characterization of the two goals that we have, the two disciplines, certainly the current SGR doesn't meet those. But at the same time I guess there's a question of whether targets can meet those. And I think in terms of the report, trying to work through how targets can be improved to try and help with both of the disciplines that it just does a fantastic job of talking about those.

What comes across for me is both the information needs that would be needed to maintain any system that we adopted, but also the information needs to choose a system to adopt and the fact that today we're not at a point where, in some of the trade-offs that were discussed, that we can say exactly where we are with respect to those trade-offs because we don't have enough information to understand them. And that really needs to be sorted out in terms of making choices.

There's a few things that I guess I'd like to
underscore. The one that I think is critical is that we start with a payment system that's sound, that the relative fees are in the correct proportions, and that they're for the units of service that make sense. Which leads to an issue of not having the fragmentation we have, but to bundle things that are more appropriately bundled.

The critical importance of this is because I think that there is the potential that even with the right targets and the right structure that if the fees are wrong, there's the potential that you can do better as an individual by being a bad apple, by just ignoring what the incentives are for an accountable units, and saying I'm going to go my own way because that's the best way for me. We've seen that today and we could see it again unless we get relative fees right.

This goes, I think, to what Jay mentioned in terms of the competitiveness of the situation will produce a dynamic that's positive. I worry about the heterogeneity of markets across this country, that in some of our markets there isn't enough competition and the potential for a larger entity to be a bad actor is very real. We need to think about that so that we can create the structure that
minimizes any damages that are associated with that.

We also, I think, need to recognize in terms of the information needs and making choices, that we're exploring new territories. When Elliott Fisher was here and discussed the extended hospital staff as the accountable unit, one of the things that came across for me very strongly was the very great differences in the patterns of use between large urban and small urban and rural areas.

One can easily say we just need to risk adjust for that. But this is the kind of risk adjustment we haven't been doing in the past because it relates to the scope of services that individuals are receiving from a set of providers, as opposed to just their health status. And that's not something that we've got the risk adjustment models for today, because we haven't been thinking in terms of accountable hospital units up to this point.

We also need to start thinking about other factors that might influence service utilization, such as the composition of the patient population. We don't want to create a situation where there is a particular problem for inner-city hospitals versus suburban hospitals because one has got a much more compliant patient population after
you've controlled for health status, and one is therefore
better than another.

The idea of extending this to other providers
makes a lot of sense in terms of Medicare having an overall
cost problem, not just a physician cost problem. But again,
the complexity of that is something that we need to think
about because other providers are paid in very different
ways. They are not necessarily rewarded in the same ways
for volume changes and they don't necessarily control volume
in the same way. Physicians are the key determinant in
terms of the use of many services. Think about inpatient
admissions to hospitals. We pay for the admission in total
and we pay an individual hospital on the basis of the
national costs.

So the question is, if we're trying to bring that
hospital into this system and give them incentives to change
its behavior in some way, how are we going to do that in
terms of the underlying payment that goes to that hospital?

Let me stop you. I think those are the things I
think that are important that we emphasize in the report.

Thank you.

MR. MULLER: Consistent with what Jay and Bill
have said, one, I want to commend everybody who has worked on this. And also, in terms of their themes.

The SGR points out the difficulty of controlling volume by hammering on payment rates. We've seen over a course of years, not just in this discussion and others, that we have a lot of increase in activity and utilization in the Medicare program largely due to increases in technology that advance the health of the population, incentives to providers, and also beneficiary choice.

There's a kind of confluence of technology and beneficiary preference and provider incentives coming together to increase utilization quite a bit inside the program.

The SGR acknowledges we have this major increase in utilization but says we'll hit the nail with the hammer that we have, which is payment reductions. In some ways, I would like that we say that that's the wrong hammer to hit, because we have to take more direct steps to look at utilization.

We'll be discussing tomorrow some modest efforts towards that, in terms of bundling of payments in the inpatient setting and some other changes in the outpatient setting for example, and also looking at some of the bigger
cost areas in the inpatient setting such as heart disease, respiratory disease and so forth. I think we should keep moving in that direction towards greater bundling. I think the comments of, again, Jay and Bill have already indicated how difficult it is to make some of these changes by moving the target system and the control system to other providers besides physicians.

So I would encourage us to keep focusing on those kind of modest changes that affect utilization. I think we all wish they were more profound ones that we have, but I think the discussion very well illustrates how difficult it is to really change utilization in any kind of profound way, given the very extensive discussion of the administrative complexities of whether one looks at -- especially the most extended discussion we have inside the chapters around geographic variation.

Obviously, there's a lot of great attraction, given the work of the colleagues at Dartmouth, to look at geographic variation and have some concern that there's something wrong about it. On the other hand, as to how to fix it becomes, as the chapters indicate, very, very complex.
I would, though, take one of the ideas that Elliott Fisher and others have urged us and is contained within these chapters, which is to keep focusing on incentives for more accountable units inside the program. I think there's a considerable consensus inside the Commission that that's a good way to go. It's a long road to get there. And that unfortunately there are many parts of the health care system that can't fall easily into accountable units right now. That doesn't mean that we shouldn't be making efforts to move more fully in that direction.

Obviously, organization such as the group practices, such as the one that Jay is in, have an advantage in moving in that direction. I think we should commend them for having that advantage and keep moving in that direction. There are hospitals and medical staffs around the country who could also move in that direction as well, understanding that in some places that's more difficult to secure, that coming together.

So my preference is to both summarize this by saying that if we have a utilization problem we should keep looking at the utilization problem and taking the kind of steps we can take as best we can. And we have over the
course of recent years, we've looked at certain appropriate standards on utilization, on imaging services for example. So I don't think we have to reference all of them again, but we have taken steps to try to look at utilization controls. And again, tomorrow we'll be talking about further bundling.

But I have a very strong preference for saying that if the problem is utilization, don't fix utilization by cutting rates. That's wrong when you get there. In fact, as I think either Kevin or Dana said in some of the introductory comments, there may be this perverse effect that by hammering the payment rates you, in fact, exacerbate the utilization problem. I think there's evidence to that effect.

So if, in fact, we're increasing our problem when we're trying to fix it, we should at some point say let's stop going at least in that direction.

MR. BERTKO: I, too, would like to commend staff for looking at all the many details in the mandated Congressional portions. And then I'd like to lend support to pathway two, in particular. I'm going to follow up on some of Ralph and others comments here.

The real target ought to be combined expenditures
and whether its utilization or rates or intensity and new services, that all ought to be combined together, and that we should be, under pathway two, encouraging formation of these accountable care organizations with an emphasis on care coordination.

I think, as Ralph said, but I'll be even more explicit, this is a long-term process. This is probably a 10-year process, from everything from encouraging the set up of these organizations, and Ron and I were talking about medical education as being a part of it for new physicians.

One part of this that I think in pathway two needs to be retained and maybe even emphasized is retention and use of the target of some sort as perhaps a default that says if a group or a physician or an organization does nothing, they stay in something similar to the current SGR or something modified along those lines. And that, in turn, means that if you move into an accountable care organization you have a good chance of making a change and improving the amount that you're paid on this in the appropriate way.

The last comment is really to the report itself. You've got a lot to talk about here. And having a greater amount of focus, perhaps on pathway two or pathway one both
as defined alternative that Congress and staff could react
to would seem to be something that might be useful.

DR. WOLTER: Just a few comments. I'm not a fan
of continuing the SGR in any fashion. I think any benefit
that it has created in terms of highlighting the volume
problem or any blunting of reimbursement that it has created
has been more than overridden by the problems it's created,
and including some of the behaviors that are leading to
increased volume in other ways.

Another area where I think it has created problems
as the whole thinking about pay for performance in the
physician sector, which I happen to think is on a very bad
track. We're trying to solve reimbursement to physicians by
creating measures for every specialty rather than focusing
our thinking on pay for performance in those high-cost high-
volume disease areas.

I think in so many ways the SGR has had
detrimental effects. It's created a sense of a punitive
approach in one sector where we haven't done this in other
sectors.

I would not be opposed to something that's fairly
painful, which is no updates for hospitals and doctors
except for those who move into other accountable paths of
care. I think there's ways to think about this a little bit
differently. But if there's anything that's had a track
record of complete failure, I think the SGR would be near
the top of the list. And so I think there's other ways to
get at whatever the benefits of that have been, if any.

Another thought I've had is in the past when we've
seen a problem in a given sector we have said we're not
going to increase the update across the board. We're going
to try to focus on the problem in a different way. We won't
use the overall update as a way to do it.

Well, we're doing that in the other way here.

We're using a negative update to try to deal with a problem
that could be dealt with in a more strategic and focused
way. And that's why the recommendations that are more
specific around pricing, et cetera, are so important. And I
think if we would highlight that we need to aggressively
move to these strategic tactics that in the short to
moderate term could help us create more value, that would be
more useful.

I also wanted to mention in the outline, which I
thought was very well put together, in five we say improving
the value of the Medicare physician payment system. I think we really have moved to a discussion of improving the value of the Medicare payment system. And it might be better to just go ahead and reflect that. Because whatever we put in place in terms of cost control measures, I think there is agreement here it needs to be expanded beyond the physician-only sector.

We mentioned in executive summary, I think the issue of self-referral and conflict of interest needs to be added to our list. I know that's a very controversial area. It's very likely to be a driver of volume, at least to some degree.

I think when we talk about that there's so much focus on the physician. But in fact I know very well that there are many behaviors and hospital strategies that are volume drivers, and some of those bleed into the physician issues in terms of high dollar recruitments and other strategies to drive volumes on the hospital side. So that whole issue of where the hospital side fits into volume growth probably needs more discussion and more attention.

Another thing I think that's important here is in some ways if we could strengthen certain areas of physician
reimbursement so that there were appropriate incentives to help us reduce hospitalization, reduce readmission, do better chronic disease management. There are proposals from various groups on medical home or better chronic disease management. It's quite possible that physicians would find involvement in those activities preferable to trying to put a CAT scan or something in their office.

So I think, in some ways, we could benefit from investment in certain areas of physician and reimbursement than what we've been doing.

Another point I really wanted to emphasize is that as I look at the report, which by the way I agree really is marvelously done. It's going to take a few more iterations, I think, for this to emerge in terms of what might be a good framework. But we're talking about some short to medium term policies that might help us really tackle the problem. But we're also beginning to talk about some long-term framework that's really about the reorganization of the underlying health care delivery system.

I think if we can emphasize that that's a long-term goal, because the current state of the hospital medical staff clearly is not set up for what we're talking about.
So we have to look at this really as a transformation that's going to be over the next decade or perhaps a little bit longer.

We have administrations that change, we have CMS executives that change, we have so many things that change. But I think MedPAC could make a contribution by trying to reiterate over time a somewhat consistent long-term vision for how the infrastructure of health care delivery does have to be transformed so that we can create some accountability differently than what can really be handled in the current fragmented system. And so that's in our report but we might be able to highlight that a little bit differently.

I like Jay's comment this morning in the exec session about maybe gainsharing is a little bit of a loaded term because of its history. I was thinking about that. I like the term shared accountability because really we're talking about not just cost savings but quality improvements and delivering greater value. I think shared accountability also fits nicely with some of these long-term strategies around more accountable care units.

I think those are my key points.

DR. KANE: I'm very enthusiastic about emphasizing
the infrastructure. Actually I think it can be done much faster than we're giving the system credit for. If you think about the mid-nineties, when everybody thought capitation was coming and hospitals and providers all got together and formed integrated delivery systems. And then they just stopped because nobody did it. The capitation revolution never came.

I noticed this a year-and-a-half ago. Suddenly, we stopped mentioning the notion that we can pay on a capitation basis and we've moved back to how do you balance out fee-for-service with volume? Which everybody pretty much knows is impossible, but capitation does do that.

So I guess I would just like to have the word capitation reintroduced to our vocabulary and perhaps start thinking again about what infrastructure enables us to pay on a capitation basis, not necessarily through Medicare Advantage but out there in the more general world out there.

I think the intermediate target should be the infrastructure, not the long-term target. The long-term target should be capitation with all kinds of protections against underutilization as well as over-utilization or inappropriate.
The same kind of thing that made us backlash against managed care, I think we have to put the protections in on the Medicare side. But we really have to think about an integrated payment unit that has all services under one payment and that the providers, who are frankly the only ones who really know what good care is, and are fully responsible for that.

And having Medicare policymakers trying to second-guess what's good care by altering this fee and that payment, it's impossible. So I think at the federal level we should really be thinking about how do we try to get back to a capitation-like environment, how do we encourage the infrastructure that allows people to take full responsibility for a population of care in a geographic area.

I realize we're still envisioning fee-for-service or bundled. But let's go all the way and call it what it really is. Because then I think we can think much more constructively about what we need to safeguard the system from. It's not over-utilization there, it's actually underutilization. We need to really take that seriously, as well, and think about how do we -- I mean, gainsharing was
actually there as a concern, that when physicians have an
incentive to withhold care the beneficiary is at risk. And
that's still the case.

And bundling does the same problem. So we don't
talk much about what happens with underutilization in this
whole environment because we're worried about over-
utilization. I think we ought to think about really the
right thing to do is probably get towards a capitated
environment and then how do we create the safeguards and the
infrastructure to make it politically palatable and
something that both providers and the beneficiaries would
buy into.

I think the other piece that seems -- well two
other pieces, I guess. I guess this is still in my
capitation mode. We don't look at the health of the
population enough as part of the concern, and that maybe as
we think about targets, they're all based on -- we mostly
talk about expenditure targets. But can't we break
geographic areas down and also look at the health of the
Medicare population and have that affect either capitation
levels or whatever payment unit we end up with?

I feel Jennie speaking in my ear, that we need to
have some sort of concern about the health of our beneficiaries out here, and that efforts to measure that and have rewards based on the health of the population in a geographic area could also -- not just expenditure targets and volume. We're really kind of looking at the detail without looking at the overall outcome, which I think could guide us in what would be an appropriate way to set capitation or adjust capitation.

And I guess my last point is that the SGR -- and now I hear Arnie talking to me. There's a lot of ghosts in this room.

The SGR is really Congress's way of saying how do I make sure that the Medicare program is affordable to the taxpayers? And yes, they are one-third of the people paying this bill. The people paying this bill are actually taxpayers, workers and employees, and beneficiaries. Actually I'm most worried about beneficiaries at some point. Perhaps instead of an SGR based on whether taxpayers can afford it, we should tie it much tighter to whether beneficiaries can afford it.

You've got that nice chart about where premiums are going for beneficiaries relative to their Social
Security income. Why is the SGR just worried about taxpayers? So in a way I feel like the affordability issues are not fully articulated and they're looking at the one group and there's actually three groups of payers, employers and employees -- who by the way can't even afford their own insurance right now. And then there's the taxpayers, who can afford the most perhaps, although we're in deficit so obviously we're not paying our bill. And then there's the beneficiary.

So I don't know, even thinking about what's affordable to me, if you're going to really go into SGR and say it should be there to discipline policymakers. We've taken a pretty one-sided view of what's affordable. So if affordability and putting the discipline of affordability on policymakers is part of this process we need to maintain a discipline, I would throw in the other two parties who are involved here and talk about whether that's affordable to them, too, as a way to keep the discipline on the policymakers.

So I don't know, it's a lot of different thoughts. But it's just a little bit different twist on the way we've presented it here. I just think we've presented it as
probably the most complex and hardest way to visualize what's going happen, by going at payment, volume, episodes, down to the nitty-gritty. I think we need a broader view at this level that's much more feasible to envision. But I did like the report and I thought it addressed Congressional requests very well.

DR. HOLTZ-EAKIN: At the risk of letting the staff get too full of themselves, I guess I have to also compliment to on the -- nah, I'm not going to do it then.

No, this is a wonderful report in that it highlights to the Congress just how difficult a question they've asked an answered to. It really is hard. And living through this report is getting a crash course in the Medicare system for sure, but American medicine as well.

I just want to say that, in the final version I want to also put in a plug for pushing the second path and say a little bit about how this ties in with some other things we've been concerned about.

The first is the sustainability. SGR's first letter is sustainable growth rate mechanism. We know that that's not true because the current system and the current medical system is not on a sustainable trajectory. And to
repeat the things that are easy to forget, if we simply repeat the history and go forward as things currently stand, this program will grow to more than half the size of the current government or the current size of the federal government over the next five decades. It is something that is truly beyond belief.

And at the same, if we don't change this system, we will sit around this table, or our successors will, and be unhappy with the affordability of the care to beneficiaries, their access to care in some dimensions, and the quality of care that they get. So that it is incumbent upon everybody involved to change the nature of the Medicare system and the health system that's underneath it.

That's an observation that I think just can't be lost.

As part of that, the report contains, and the discussions of this group have illuminated, an enormous number of ways that we could do business better. The current system provides just ample examples of bad incentives for bad apples and inadvertent or deliberate overuse of particular therapies and pieces of modern medicine. So it is important to move down the path that
involves higher quality care, coordination of care, understanding what we're getting out and not just paying for what we put in and how often we do it. All of that is essential.

However, in the absence of a demonstrated way to do that and a demonstrated success in doing that and bringing the cost trajectory under control, I think it is essential to retain an expenditure target in the system. And I say that knowing that the current expenditure target has produced all sorts of problems. Certainly it has produced some perverse incentives at the provider level, in part because it's too narrow.

So the second part of that path that I want to essentially endorse is a broader expenditure target mechanism that brings in, in particular, the hospitals. I think you've got to get the hospitals and the doctors together on this. Those are some of the low hanging fruit for getting costs and quality to line up the way we want.

It is however, I think, important to recognize that a lot of the problems that are attributed to the SGR are not the SGR's fault. I want to talk for a moment about the language used in the draft report and make sure we're
careful in how we talk about concepts like baseline budget scoring, as if those are exercises in fantasy accounting that aren't real.

In fact, if the Congress were to waive the SGR, we would spend more. That's not fantasy. And beneficiaries would pay more and taxpayers would pay more and outlays in the federal government would go up. Waiving that is not something that somehow waives a fantasy accounting. It's embracing a cost that the Congress has been regularly avoiding the bill.

That's all there is to it. This is not an SGR problem. This is a Congressional behavior problem. So one of the things that I think is valuable about the expenditure targets and why any new system should both retain an expenditure target as an affordability gauge but also as a discipline on the policy process so that when we create dynamics of competition at local levels, something we all believe is an imperative in a transformed system, there is not an out. And that out is go to the Congress, relieve yourself of the burden of competing with people who are doing a good job, and get your money anyway. That can't be cheap, it can't be easy and must be transparent when that's
going on. I think expenditure targets help to take care of that. I think that's one reason why path B is, in fact, the way to go.

DR. CASTELLANOS: Like the rest of the commissioners, I really congratulate the staff. I think they've done an excellent job on this, as usual.

I think under the two pathways, I think there's a lot of similarities in the pathways. I think the biggest dissimilarity is the SGR or the expenditure target. I have a very difficult time accepting to continue a problem that hasn't worked. As we all agreed, and Doug as you said, it perpetuates ugly behavior.

I'm going to step away and think about something a little different. One of the things that we said under both targets was to develop and adapt a new approach for improving value. I think we all agree we need to change the system. We need to have a more improved valued system.

Glenn, you mentioned that one of the things we need to think about doing is changing the behavior of the provider. One of the ways to do it is to change the payment policy.

What you're really trying to do here is to change
the practitioners' pattern of practicing medicine. That's what you're really doing. You're changing how I, as a practitioner, practice medicine.

I will tell you, because I talk to a world's expert every day, my wife will tell you that it's going to be very difficult to retrain me. But it's possible.

One of the things that, after looking at this report and the different spin I'd like to put on it, it's about a 200-plus page report. There was one paragraph with three sentences that talked about education, and they talked about continued education. I know it's expensive to do it but we have a beautiful opportunity and perhaps making some recommendations to Congress to implant that. And Nancy, in the past you've talked about education, too.

We have this medical student who in the next 10 years is going to be the basis for our medical community. And if we start not at the doctor level where I am, and working down, but if we start at the medical school level and start a course of medical education for cost efficiency, evidence-based medicine, coordination of care, if we can train a new generation of physician faculty where these medical students have the model to identify with, the
person, their mentor. And if we can expand that into the residency program a lot of these problems of education and changing behavior will be automatic.

It's sort of like the computers. To teach me how to do a computer is going to be difficult, but my grandkid does it. And he does a good job by teaching me how to do it. And I think the same philosophy can be said here.

I'm a little embarrassed to say that I see nothing in this report about education. I would strongly emphasize that we, as a Commission, make some recommendation on an educational basis starting at the medical school level.

MS. BEHROOZI: Yes, just to add my comment, thank you Glenn, for helping us to distill all the various thoughts of the commissioners into these two paths. And thanks to the staff for pulling all of those things that we've been talking about, all of which was new to me a few months ago, but to see it all put together in one place with an outline and everything, it's really very helpful. It's really great.

Just two comments. It does seem like there's a reason to retain targets because just the pricing obviously doesn't work on its own. The responses to the pricing have
the opposite of the intended effect sometimes, as you lay
out in the report. So it does seem that targets are
necessary.

But to have one overall target that has such
draconian effects, part of which is because of the
cumulative nature, I think while it's true, Doug, then
people have to kind of go with hat in hand and say so maybe
you want to take care of me even though I'm not doing so
well.

On the other hand, when the punishment seems so
severe then I think it elicits a response that is not
necessarily tailored to the best policy judgments but rather
to how big a whack, how blunt the instrument seems to be, as
people have said.

So I do think that in crafting the target it's
important to look at some of these different areas that
Congress has asked us to look at or the staff has brought up
to try to tailor better the targets to the goals and then
not create such an incentive for a general override. The
fairer the system the more likely it is to be upheld.

In terms of some of those choices, those policy
choices, the staff has identified in the report some areas
where there might be political backlash or thresholds of acceptability, or whatever that might be, kind of high like with respect to the type of service notion that it could put policymakers in the position of determining what represents good care. And Nancy thought that wasn't such a great idea. But the other hand, at the very beginning you identify some of the key issues, encouraging the optimal mix of services. Even when we're talking about quality and talking about -- throughout the report there are other places we talk about things like cost-effectiveness. We might not all agree on those, but I would suggest that it is actually a function of policymakers to decide what is good quality, what's an optimal mix of care, and to some extent then what is good care. And so that might not be low-hanging fruit in terms of what you'll get policymakers to agree on or get the public or providers to all accept all at once. But that doesn't mean we shouldn't try.

Nick referred to the longer-term contribution of MedPAC to the policy debate, and I think we shouldn't back off of pointing out that if Medicare is going to be a purchaser of services really -- I mean the way it's worked, particularly in fee-for-service is just to be the back-end
payer and let providers and beneficiaries choose the
services.

But really if you look at the Medicare program as
a purchaser of services I think that we need to start
thinking more like the government when it purchases other
services, when it uses procurement rules and things like
that, what's the best value. I think a lot of the comments
from different perspectives and in different ways move us
towards thinking about value, which means we have to start
getting Congress and the public ready to recognize that yes,
there might be some decision making at some level by some
authorities about what is good care, what is quality care,
what's worth paying for, and what's worth paying more for,
what's worth paying less for it.

It's the kind of thing that obviously there's been
backlash against it in the managed care setting. But I deal
with it every day in my day job, trying to get buy-in from
our population of beneficiaries. When we tell them look,
there's just not enough money to pay for everything in
unrestricted amounts, so we are going to take into account
your concerns, the professionals' concerns, your providers'
concerns. But in the end we can only pay for a limited
amount of things and so we're going to try to make the best choices with your constant input.

I think that means that we also have to recognize that when we talk about looking at value or at what represents good care, we constantly have to include Jennie's voice and say that there must be beneficiary input and review and responsiveness to the interests of beneficiaries all along the way in making those judgments.

DR. HOLTZ-EAKIN: I just wanted to react to something you said and also what Nick said, and one last piece on how I think this second path should play out.

Nick described the current SGR as a complete failure. I think that's too strong. If you take an expenditure target at face value, its goal is to constrain expenditures. And the SGR has done that. We have less spending than we would have in the absence of that mechanism. I don't believe that you can make a compelling scientific argument to the contrary. So it's done part of what it was supposed to do, which is control spending.

We're not happy with some of the other things it's done. I'm willing to agree with you on all of those. But it has done part of what it was supposed to do. That's
Point number one.

Point number two is I think it's important to recognize that the minus 5 percent updates and all the things that are in the formula are not actually where I think the appropriate attention should be. The appropriate attention is on what the Congress has done in deciding affordability on an annual basis. The way this is working at the moment is that Congress every year says okay, what can we afford?

That's not an unreasonable thing to ask of our Congress regarding a major program like this. I actually don't think that's wrong. And that's why I think an expenditure target is an appropriate thing to include in path number two.

We just want to have an expenditure target that works better toward controlling expenditures, so it should be broader. And that doesn't mean it's a substitute for the other things that we need in the program. It's a complement to the appropriate pricing and the whole plethora of things we've discussed about getting the quality and cost of care to line up right.

And so I don't want somehow the experience with
the current SGR to somehow damage the notion that it is sensible, in the absence of demonstrated success on low-cost high-quality care, to in a sense have an affordability check. And that's what an expenditure target gives you.

DR. WOLTER: I haven't had so much fun with point/counterpoint for awhile, Doug.

DR. HOLTZ-EAKIN: I'm not done.

[Laughter.]

DR. WOLTER: I'm sure you're not.

But I do think you could make a very logical argument that, in fact, the current baseline budget is a fantasy budget. I believe that there are a lot of things about it that are so unrealistic, and that we haven't held ourselves to, that any person used to doing their own monthly budget would look at this and say this is a pretty unrealistic situation. I think even some of the reports we've recently reviewed would say that.

I also think you could make a fairly logical argument that one of the effects of the SGR has been behaviors that have actually increased expenditures in the Medicare program. Not within the update to physicians, but within many the physician/hospital joint ventures, the
movement to physician ownership so they can get technical
fee. And I think that it's quite possible that if we could
do an analysis of that, we would find that we've driven
costs up because of behaviors in response to the SGR. That
would be at least a reasonable premise to explore.

DR. REISCHAUER: So Doug, a tag team here. We
have the same DNA structure that we're reflecting.
I don't think Doug is saying that the baseline
budget, assuming an effective SGR, is realistic. It's not.
But the question is where is the expenditure vis-à-vis a
situation in which there were no SGR at all and we were
giving MEI updates each year.

What he and I are saying, and I said before is, it
would be somewhat below.

Nor are we saying that there aren't areas in which
the incentives, the perverse incentives in the SGR haven't
caused a net increase in that component. But overall there
is some dampening effect, not as great as the Congress
intended but some dampening effect. And that's worth
something.

DR. WOLTER: Could I just respond quickly?

There's been a dampening effect within the sector
to which SGR has been applied, possibly overruled by the fuels that have been created in other sectors. I think that needs to be recognized. I don't think it has been recognized.

I think that the inability to move beyond the SGR discussion to true tactics that might help us get control of this situation is an issue. It's definitely an issue.

Here's where I think there's common ground on this. We need a pressure point. The question is what's the best pressure point? Is it a formulaic approach that applies to only one sector? I would agree with Doug, that doesn't work. If we need a pressure point, it should go across the program.

But is it to use this current baseline or is it to be realistic and say where we are, we're going to do something fairly disciplined about how we look at updates. Maybe it's zero percent for a while until we get some of these new behaviors in place while we introduce these other tactics.

I just would like us to get to a realistic set of strategies that can help us deal with the issue.

MR. HACKBARTH: I would like to jump in here for a
second on behalf of Arnie and Karen, neither of whom is here for reasons beyond their control. I had promised each that I would try to offer some comments on their behalf. I think Arnie would have his hand up at this very moment, wanting to leap in.

Arnie would strongly support the view that we need to maintain some form of expenditure target. Indeed, he would take the added step of opposing any forgiveness of the existing debt, believing that we need a very strong tool to encourage providers to change behavior.

His notion of how that would work is that if you want to get out from under this threat of not just constant fees but declining fees, you need to reorganize yourselves and create a variety of different paths for doing that. Whether it's an accountable care organization that's built around a group practice or integrated system, or something that's more suitable for physicians in solo or small group practice, he wants the threat of cuts in fees to be there as an inducement for shaking up the way care is delivered in the U.S. not just for Medicare beneficiaries but in general.

He would strongly agree with Nancy's points about concern about the impact of all of this on Medicare
beneficiaries. He, too, believes that that gets too little emphasis. Taxpayers are important but what concerns him equally, if not more so, is what's happening to the ability of Medicare beneficiaries and other workers to afford health care. We are rapidly, in his view, making health care unaffordable to Medicare beneficiaries and workers who are not at the upper end of the pay scale. And that is a matter of great urgency, in his view.

Given all that, his biggest reservation about path two as described in the draft report is it's not nearly fast enough. The time line, from his perspective, is glacial in its pace. And he thinks that we need to be much faster, much more demanding, and ought to be working hard to get Medicare caught up, in his perspective, with tools that have been in place in the private sector and shown to be working there.

Finally, Arnie would also agree with Ron's comments about medical education. All of you will recognize this as a theme of his, that one of the things that we need to be doing is changing the pipeline both of terms of the type of physicians we're producing. An example he's often cited there is way too few geriatricians. But also not
educating the broader class of physicians in the skills that they'll need to practice successfully in the 21st century. And so that is a matter of concern to him, as well.

Let me then turn to Karen's comments on SGR. She strongly believes that the current SGR is so flawed that it should be abandoned and she would like to see that flavor come through more strongly and repeat some of the things that MedPAC has said in the past about that.

She said if we choose to offer a path with some other form of expenditure target, for heavens sakes let's call it something else other than SGR. I think there she agrees with Jay that sometimes these terms have such bad historical connotations that the terms ought to be abandoned.

She said let's explain very clearly why this new alternative would be better than the old SGR and not subject to the same flaws.

In the same vein, she's concerned about the use of the term outlier as one of the mandated options. She understands why people are inclined to use that term but she thinks it's a very loaded term and one that almost condemns the idea.
You know, from Karen's previous comments, that she thinks it's very important to provide physicians with information about how their practice patterns compare to their peers. And so she doesn't want to see the idea condemned with a bad label. She suggests that we not call it outliers but something like clinical resource consumption, clinical resource measurement and the like.

So those are some comments from Karen and Arnie.

Before we go on to other comments, let me just address one other thing that may be on the minds of the audience, if not of Commissioners, and that is why not a vote on what to do with SGR.

Instead of a vote, as we've discussed repeatedly now, we are saying here are a couple of alternative paths that the Congress might pursue. I've thought long and hard about whether it would be appropriate to do a vote, and Ron raised this question earlier today. That would allow observers, including the Congress, to see exactly how we're divided. I think it's evident to everybody in the world that we are not of one mind on this topic.

So yes, a vote would accomplish that. But I think that that advantage would be overridden by the disadvantage
that a lot of these ideas are still too abstract for us to fully understand what it is we're voting for or against. I think that to the extent that MedPAC is valuable to the Congress, it's because we tend to be pretty careful about things like that. We don't just abstractly recommend things, for the most part. We try to be more disciplined than that and have a pretty concrete idea what we're talking about, what its pros and cons are, so we can speak to those. Here, due to the time constraints that we've had, we are far short of that point, to be able to say with confidence we know exactly how path two would work and we can assure Congress that the advantages will outweigh the disadvantages. I don't think a serious person can make that assessment at this point. So my judgment is the best thing to do is to say here are paths that might be pursued and developed further.

Now we can go back to other comments.

DR. CROSSON: I'll reiterate a little bit and point out that I think in the end the work and the effort that we devote to the target or the not target probably should be about 10 percent of the effort. And the effort that gets devoted to creating the dynamic or the set of
dynamics that will lead to appropriate utilization and quality is where the effort ought to be.

I think whether you want to call it a target or a baseline, talking about updates, there has to be some starting point. That starting point could very well be input costs, or it could very well be the perspective of the Congress as to what is affordable. And that, in any particular moment, might not be input costs.

But then what really does matter is what you do about creating incentives and who those are for and how they're organized and how they're gaited and the like. And I think if I were involved in trying to take this report at some point and begin to build it into something that could work, that's where I'd spend 90 percent of my energy because I think that's where the gain really is. If the SGR has saved money over time, it probably has because if there had been no target of that nature there probably would have been more spending than there was.

But yet this type of target in itself doesn't solve the problem. So I just think it's just a question of where the mental energy and the design energy out to be devoted. And it's not really to a finer and finer
discussion of what the baseline or target ought to be. I don't agree though, having said that, with Arnie's putative idea that keeping in place the current SGR pit of minus 35 percent or minus 95 percent or whatever it works out to be is either necessary nor effective. I think it, in fact, is generally widely believed is unbelievable or unmanageable or unworkable and therefore can be dismissed by people.

Whereas a system of slow inexorable competition with 2, 3, 4, 5 percent differentials year-to-year figure is very believable because it would be experienced at the local level and it would, in fact, create the dynamics that we're interested in.

I also believe what Nancy said, which is although I am in no way underestimating the complexity of this, I think were this type of dynamic to be created, as we saw in the early 1990s, things would get moving a little faster than what people might think.

Now having said that, a lot of these efforts were clumsy and didn't work. But some did. It was abandoned relatively quickly before I think there was an opportunity for learning to take place.
So I really don't believe that this is 10-plus years. I think it could occur a good deal more quickly.

DR. REISCHAUER: A comment on Arnie's hair shirt approach and then on Jay's comments.

With respect to Arnie's view that in the long run the desirable course of action should not forgive the sector for its "overspending" in the past. I think we'd have to sit down and ask whether a premiere accountable health care organization, one that coordinates care and mixes and matches inputs and resources in a way that isn't bound by traditional roles such as the one Jay works for, could live and provide high-quality care to Medicare beneficiaries for -- I think the number is 23 percent less than what they're getting now.

I don't know the answer but Jay maybe does.

[Laughter.]

DR. CROSSON: You're mixing up policy issues.

DR. REISCHAUER: I kind of suspect that the answer to that is no because of the way things have evolved over the last 10 years have hanged the practice of medicine even within your organization.

So the question we're really left with, it strikes
me, do we think the incentives in pathway two are sufficient
so that within 10 years or so we will get a change in the
delivery system and the emergence of some kind of
accountable entities for which capitation, pseudo-
capitation, whatever, can be applied.

I guess I'm very skeptical about that, and I
wouldn't look back to the earlier period unless you knew
some way of enlisting the active participation of the non-
Medicare world in this effort. It was the non-Medicare
world that brought this about, the employer world, in the
ever 90's. You'd have to have both Medicare and that group
on board for a change like this, I think, to bring about.

And I think there would have to be more active
incentives and models for the creation of these entities
rather than just we're going to jigger around with some of
this stuff and the actors out there will do it on their own.
I don't believe they will. I think they will resist, which
is another approach when policy doesn't go in your
direction.

MR. HACKBARTH: Can I just pick up on this on
Arnie's behalf? In fact, let me just issue a general
apology.
DR. REISCHAUER: Maybe I won't come. My views will be better expressed and more frequently if I wasn't here.

[Laughter.]

MR. HACKBARTH: Let me start with a blanket apology to everybody whose views I am presenting. I'm not a worthy advocate.

[Laughter.]

MR. HACKBARTH: Having said that, I know, based on my conversations with Arnie, that there are a couple of points that he would want to make. One is about the urgency of system reform. And he would absolutely agree with what you said, Bob, about the need to better coordinate and synchronize the efforts of the public and private sectors on this. That if either public or private acts alone, the effectiveness is going to be greatly diminished. He thinks much more attention needs to be done and provided to that synchronization.

The second thing that I think that Arnie might mention with regard to what's achievable is that I think he believes that people haven't really thought seriously about what might be achievable. One of the reasons that he pushed
hard for us to have the panel on reengineering health care delivery, including the CEO from Virginia Mason, is he fears that there are way too few health care providers who are thinking about this in the right way, which is let's go back to square one in how we design these systems to improve efficiency. We need to take them apart. Just as so many other American businesses have been taken apart to deal with global competition. And that health care has been way too complacent. We have asked way too little of health care providers. And that is because it's a lot easier for them to lobby and get higher payment.

So he thinks that the amount of pressure needs to increase dramatically to force a fundamental rethinking of how services are delivered. I think all of you will recognize Arnie's voice in that statement.

Now we are down to our last five or 10 minutes.

MR. MULLER: I think the negative updates just have such a pernicious effect on behavior. While I think we all understand, based on the studies from Joe Newhouse on, that technology is the biggest driver of expenditure increases. I think when you look at some of the themes that we've looked at the last years, the growth of imaging, the
growth of specialty hospitals, the growth of ambulatory
surgery centers, of diagnostic centers, of LTCHs, the growth
in outpatient.

I think part of the behavior you see on the part
of physicians when they keep seeing negative updates being
held out there is they start looking, as Nick and others
have said, for other ways in which to maintain and have
access to income.

So while I should be hesitate to debate with two
former directors of the CBO forecasts of expenditures, I
just think that there's at least pretty plausible evidence
that the physician behavior that is in part incentivized by
the five, six, seven years of forecasting negative updates.
So even though, as we say, each year somehow the Congress
takes the step that Doug has described, I think it has this
pernicious effect on the whole system. And in my mind
therefore it is a plausible argument that it is driving up
expenditures.

Again, I think technology is the biggest driver of
that, so I don't want to then put the cause on this. But I
think it does have the effect of causing them to enter into
arrangements that the fee-for-service system tends to reward
and therefore incentivize that really drive up the cost to
the system.

Now there are other parts of our provider economy
where we give updates of 1, 2, 3, 4 percent. I'm not
suggesting that when you give updates of 1, 2 or 3 percent
it somehow mitigates utilization increases. But I do think,
given the central role of the physician in driving health
care expenditures, there is just too many opportunities the
last four or five years, exacerbated by capitalists coming
in from the equity markets and private equity and so forth,
to get into these businesses where they get a share of the
facility fee. And I think we are just deluding ourselves by
not noticing that the incentives have very much moved in
that direction in the last four or five years. I say, we
have seven or eight sectors that we have discussed at length
in the last three or four years where I think the behavior
is going on.

So I would argue that the ongoing prospect of
negative updates foster that kind of behavior. Not the
biggest cause of it, but foster that kind of behavior. And
I would argue therefore drive up the expenditures more than
they otherwise would.
So I do think that our expenditures -- you know, it's hard to prove something in the absence of it happening. I think it has, in fact, driven up expenditures more than it would have been in a world where we had -- if we had the MEI recommendations that MedPAC has been behind at least four or five years, I think that might have mitigated some of that.

MR. HOLTZ-EAKIN: Briefly just one more time around on this. The only difference between Arnie and I is he's nicer than me.

I understand why he doesn't want to waive this cumulative debt. The reason is if you just waive it, you make it free to Congress. And remember, Congress created this. This is not something that came out the SGR. This sis something that came out of Congress. Each time they gave more than the SGR would permit, they weren't honest about the fact that they had done it and pretended that they were going to take it back.

So this is something they did. And to waive it and make it free to them is, I think, not desirable because it's not going to be free to everyone else. The money will actually get spent then, if you waive this, and beneficiaries are going to be on the hook
for it. If you just get rid of the SGR and forget the
overhang, you're talking about $1,000 for every Medicare
beneficiary. They're going to really pay that. And I don't
think that Congress should do that casually or lightly.

It's producing pernicious incentives. Agreed.

But the Congress should recognize that it's worth it to put
it on the books and pay this bill to get rid of bad
incentives.

And the last piece on Arnie's incentives, if you
can then find an alternative mechanism, one that comes
faster, pushes harder, reengineers more quickly, and gets
the 25 percent reduction the SGR would have, you net zero
anyway. And he wants that incentive.

MS. BURKE: This was not my point, but at the end
of the day Congress isn't paying a thing. At the end of the
day, it's essentially the taxpayer and the beneficiary and
everybody else who's paying it. I think the reality is
they're going to have to contend with it from a bunch of
perspective one way or another. Either it's through the
Medicare program or through some other mechanism.

So at the end of the day yes, Congress has chosen
to do it. At the end of the day, we're not punishing
Congress. We're ultimately having to make a decision as to what makes sense over the long term.

I think it does create pernicious incentives and I think it has been a failure in a variety of ways. It achieved maybe some dampening effect. But I would agree with Nick, I think at the end of the day it's been a failure.

But I wanted to go back to the point that you made at the beginning, Glenn, and then the point that Bob continued on. I think you are wise not to take this to a vote. And I think for the reasons that you, in fact, state which is there is not, I don't think at the moment, the detail available to us to really understand how one might go down one path of the other. I think there are the seeds of a number of alternatives and options that we might consider.

Having been on the receiving end of these kind of reports for 20 years, I think the upside is I think the staff have done an extraordinary job of helping to articulate what the pros and cons are of each of these individual pieces, notwithstanding the fact that we really don't know how fully they would understand. In fact, if I were asked to vote, I don't where I would go because I
fundamentally am opposed to the SGR. I don't know that I
would agree necessarily with all the pieces of path two.

To Bob's point, I think there is a great deal of
complexity, as has been identified, as to how one might do
any one of these things. I do think that, if anything, the
end result of this ought to put some pressure on the
industry to begin to understand how does one retool. This
might be one area where I might, in fact, agree with Arnie,
which is not often. But I do think there is pressure that
has to be borne by the industry to understand how to begin
to retool.

But I am concerned that even in pulling together
all of these options, which I think again the staff did a
great job at doing, I think further understanding -- I mean,
the instinct will be like a menu, let's take that one and
that one and that one. I think there ought to be a
cautionary note throughout this, which I believe there is
certainly the foundation for, of the complexity of every one
of these options.

The geographic cap, for example. The specialty
cap, for example. How one might create groupings. In rural
areas in particular, this will be enormously complicated.
Among certain specialties who don't tend to refer to hospitals and tend not to do a lot of hospital-based care, enormous complexity.

I think if there was anything that, in fact, the staff as we can continue to refine this and send it to the Hill, it is to underscore that complexity, that we really don't understand how it will play out. But there really does need to be a fundamental rethinking of how we organize care and how we create these incentives. And the faster we can do that the better we will be.

But again, I think your point that we really don't yet know enough, I think there's work to be done. I think the question of how we can help CMS and invest in CMS to give them the tools to begin to help us understand how one might go about doing this, the data upon which these decisions will be based will be critical so they are viewed as fair by providers, I think will be very important.

But again, I think underscoring that complexity, understanding the need for change, understanding the need for investment now in CMS to begin to gather those tools together, I think would be the one message if nothing else. I mean, we can't choose among these. We don't really know
enough to do it. 

But clearly, the SGR is the wrong direction. But some kind of pressure that helps us force that kind of decision making, I think, makes a great deal of sense.

MR. HACKBARTH: Okay, thank you.

I appreciate all the work that you've done, Kevin and Dana, on this.

Next up on the agenda is the update for hospitals, and we're doing an audience rotation here with the physician people moving out and the hospital people moving in. So we'll just take a minute to let them get settled before we start up.

Okay, we're on to hospital updates. Jack.

MR. ASHBY: Good morning. We would like to begin this morning by returning to the issue of DSH payments and uncompensated care, and we will bring back the draft recommendation on uncompensated care data that we discussed at the November meeting.

Then we're going to briefly review our findings on IME payments and on overall payment adequacy. Both of these were discussed at the December meeting. And we will finish up with draft recommendations on IME payments and on updates
for inpatient and outpatient payments.

Once again, I'd like to take just a moment to acknowledge the input of several staff members whose help was integral in preparing our chapter. That would be Tim Greene, Dan Zabinski, Julian Pettengill, Jeff Stensland, David Glass, and Anne Mutti.

Turning to our first topic, the DSH adjustment, and beginning with a little bit of review. DSH spending is $7.7 billion and about three-quarters of all PPS hospitals get a DSH adjustment. Our analysis estimated that there were about three-quarters of all DSH payments, or $5.5 billion, represent a subsidy because this portion of the payment is above the empirical level of measured impact of low-income patient care on Medicare costs.

And finally, our analysis found little if any evidence of a relationship between hospitals' uncompensated care share and the size of their DSH add-on or their IME add-on.

As an alternative to the DSH adjustment, we talked at the November meeting about options for a federal payment to protect access to care by offsetting a portion of hospitals' uncompensated care costs. The payment could be
organized outside of Medicare and financed through a broad-based revenue source such as general revenues or a dedicated provider tax, or it could be designed as a Medicare payment mechanism, in which case the funding would come from the current DSH payments.

Regardless of which of these approaches is taken, we established the principle that the payments should be distributed on the basis of each hospital's total uncompensated care costs, which means that it would not be a per case payment.

An uncompensated care payment, of course, requires accurate data on hospitals' uncompensated care costs. Congress directed CMS to begin collecting uncompensated care data from all PPS hospitals and a form for this purpose was added to the Medicare cost report in 2003. But there have been numerous problems with this data collection effort. Some of the specific improvements that we think are necessary are detailed in the chapter and I won't spend our presentation time to go into that detail again.

This leads up to our first draft recommendation, which is that the Secretary should improve the form and accompanying instructions for collecting data on
uncompensated care in the Medicare cost report and require hospitals to report using the revised form as soon as possible.

This recommendation would have no impact on spending and would cause a small increase in hospitals' data collection burden.

We'll hold this draft recommendation for the end and go on now to IME.

MR. LISK: Moving on to review the findings on the IME adjustment, we founded that in 2004 Medicare spent about $5.5 billion on the IME adjustment, roughly 6 percent of Medicare PPS payments. The IME adjustment is set so that in fiscal year 2008 per case payments increased about 5.5 percent for each 10 percent increment in teaching intensity. 30 percent of hospitals receive IME payments and the payments are largely concentrated in urban hospitals and teaching hospitals with larger residency training programs.

Our analysis of costs in teaching hospitals found that per case costs increased about 2.2 percent for each 10 percent increment in teaching intensity, compared to the payment, which is 5.5 percent. Thus, the current payment provides a sizable subsidy to teaching hospitals, $3 billion
more than is empirically justified. That is, these payments more than exceed the higher patient care costs associated with training residents.

We also found that teaching hospitals would benefit from severity of adjustment system.

The IME adjustment contributes to wide disparities in financial performance between teaching and non-teaching hospitals. As you can see in the overhead, there's a 12 percent difference in the overall Medicare margins between teaching and non-teaching hospitals. This difference would narrow to 10 percentage points if the IME adjustment were reduced by 1 percentage point to 4.5 percent. It would narrow further to 5.5 percentage points if the IME adjustment were reduced to the empirical level. The current DSH adjustment contributes only a small amount to this disparity in financial performance between teaching and non-teaching hospitals.

At the last meeting, we also discussed three potential uses for the funds above the empirical level. One is returning them to the base rates to improve payment equity across providers. A 1 percentage point reduction in the IME adjustment to 4.5 percent would result in roughly a
1 percentage point increase in base rates for all providers. Alternatively, these funds could be used to support a pay for performance fund for all hospitals, providing higher payments to hospitals that perform better on quality measurements. A 1 percentage point reduction in the IME adjustment would support about a 1 percent payment pool for such an initiative.

A third potential use of these funds is to help support innovations in residency training.

We're now going to move on and talk about payment adequacy and will return to the recommendation on the IME adjustment later.

MR. ASHBY: Turning to overall payment adequacy, most of our indicators are positive. First, access to care remains strong, as indicated by more hospitals opening than closing since 1999. In fact, the annual number of closures has dropped by more than 60 percent since 1999. And the share of hospitals offering a set of inpatient, outpatient and specialized ancillary services remaining stable or increasing. The number of Medicare discharges and outpatient services has been steadily increasing, although the rate of increase slowed in 2005 and into 2006. The
complexity of both inpatient and outpatient services has also been increasing.

Quality of care is generally increasing with mortality and process measures showing nearly uniform improvement and mixed results on the rate of adverse events. And finally, access to capital is good. In fact, by some measures it's at an all-time high.

On the rate of cost growth, the weighted average increase in Medicare inpatient costs per discharge and outpatient costs per service has fallen from 5.3 percent in 2003 to 3.7 percent in 2005. That 3.7 percent figure is only a few tenths higher than the operating payment update in 2005.

But we have preliminary evidence, from a survey of about 600 hospitals that we cosponsor with CMS and from six for-profit chains, that the rate of increase may be up as much as a percentage point in 2006.

Key factors in the escalating rate of cost growth appear to be a substantial increase in capital costs, and that's certainly related to the 30 percent increase in hospital construction we saw in 2006, and the fact that hospital employment rose faster than volume in the first
half of 2006, which may be a temporary phenomenon related to slowing growth in discharges and outpatient services.

MR. LISK: Let's move on. This leads us to an estimate of overall Medicare margins which includes all lines of service provided to Medicare patients in the hospital. Our estimate for 2005 was minus 3.3 percent, 0.2 percentage points lower than it was in 2004.

The projected margin in fiscal 2007, accounting for 2008 payment policies, is estimated to be minus 5.4 percent. The decrease is largely due to the expected higher cost growth in 2006 and 2007 that Jack just mentioned a moment ago.

Returning to some of the other findings we had on financial performance presented at the December meeting, we found that hospitals with consistently low Medicare margins have higher cost and higher cost growth than other hospitals. Hospitals with consistently low margins do not appear to be under as much cost pressure as hospitals with consistently high margins. The non-Medicare ratio of revenues-to-cost, the measure of financial pressure, is very different between these hospitals, hospitals with consistently low and high margins.
This ratio stands at 1.16 for the low margin group compared to 0.99 for the high-margin group. The low-margin group may face less pressure to control their Medicare costs as non-Medicare revenues greatly exceed costs and they can rely on these excess revenues to offset their Medicare losses. In fact, these hospitals have actually seen revenues grow faster than costs, another sign that this group is facing less financial pressure.

The ratio non-Medicare revenues to cost for hospitals with consistently high margins is only 0.99, which means these hospitals are almost breaking even on their non-Medicare business and that they need to do well under Medicare in order to perform well. Thus, lower cost and cost growth for this group appear to be associated with the financial pressure that they're under. Hospitals with consistently low Medicare margins are also not competitive in their markets compared to their competitors.

In a related analysis, we found that hospitals with consistently high costs pull the industry-wide overall margin down 3 percentage points.

Jack and I are now going to walk you through the recommendations on the IME adjustment and the hospital
update. The recommendations are interrelated in some ways, so you may want to consider them as a package for improving the payment system.

Now we return to the draft recommendation on the IME adjustment. There's a slight change from what's in your report to what's here, and I'm going to go by what is generally in your written material.

So reading what the recommendation is: concurrent with implementation of security adjustment to the DRGs, the Congress should reduce the indirect medical education adjustment in fiscal year 2008 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained from reducing the adjustment should be used to fund a quality incentive payment system.

The spending implications for this recommendation are none, since the proposal is budget neutral. Under beneficiary and provider implications, this recommendation would reduce IME payments to teaching hospitals but would redistribute payments to hospitals that perform well under a quality incentive program including teaching hospitals.

We must also note that our analysis shows that teaching hospitals will benefit from the implementation of
severity adjustment to the PPS rates. With funds from reducing the IME adjustment used for pay for performance, there is the potential for improved quality of care for Medicare beneficiaries.

We make this recommendation because the IME adjustment is set considerably above what is empirically justified, leading to substantial disparities in financial performance under Medicare between teaching and non-teaching hospitals. These funds are provided to teaching hospitals without any accountability for how they are to be used.

Teaching hospitals will also benefit from the impending implementation of severity adjustment to the DRGs. The Commission believes a credible severity adjustment system is necessary to help improve the accuracy of the payment system.

This recommendation would also provide the initial funding for a quality incentive program for all hospitals, including teaching hospitals, which the Commission previously has recommended.

In 2005, the Commission recommended the implementation of a quality incentive program. The Commission recommended that the program be funded with a 1
to 2 percent payment pool. Our IME recommendation would
fund about a 1 percent payment pool. If we wanted the pool
to be closer to 2 percentage points, the added funds would
need to come from the base rates from all hospitals. Some
of the underlying principles of the Commission's
recommendation included that the programs would reward both
attainment and improvement in quality performance and that
the pool should be expended with funds redistributed back to
hospitals that perform well on quality measures.

The Commission also thought that this program
should be implemented as quickly as possible, but it has
been two years since we made our recommendation and a system
wide quality incentive program for hospitals has not yet
been put in place.

The quality incentive program would replace the
current pay for reporting system, which reduces payments by
2 percentage points for hospitals that do not report quality
data.

MR. ASHBY: Now we turn to our update
recommendation. In considering the appropriate update, on
the one hand our indicators of payment adequacy are almost
uniformly positive, as I mentioned earlier. But on the
other hand, Medicare margins remain low and recent cost
trends suggest that they are likely to be lower in 2007.

At the same time though our analysis of hospitals
with consistently high costs and low margins suggest that
there's wide variation in cost and financial performance and
that a fairly small minority of hospitals -- less than a
fifth -- have caused the negative aggregate margin for the
industry.

So balancing these considerations, our draft
recommendation, which will apply to both inpatient and
outpatient payments, is for an update of market basket to be
implemented concurrently with the pay for performance
program.

This recommendation differs from the one we put up
in December, which was market basket less than half of
expected productivity growth, which we had carried over from
last year as a starting point for discussion.

The implication of this recommendation is that if
a 2 percent pool were used to implement P4P, for example,
with part of the pool coming from the IME change and the
rest taken from base payments, then quality performance will
determine the net increase in payments that hospitals
receive. Poor performers would have a net increase of less than market basket while good performers would likely have a net increase of more than market basket.

Now just to be clear, the P4P program would operate completely separately from the update but it would be the combination of the update and the hospital's performance in the quality arena that would determine it's net change in payment for the coming year.

At this point, we can open up discussion on each of our three draft recommendations.

MR. MULLER: Glenn, I appreciate the sensitivity you've displayed in trying to come to a reasonable consensus on these recommendations. But I want to speak to the payment adequacy findings first, because I find it inconsistent, almost perverse, that we say that the indicators of performance are positive. That's largely based on what's happening in the market outside of Medicare. It's because of the higher payment rates in the private market.

And by and large, as a Commission, we've said we're going to look at Medicare margins, not at total margins. So for the sake of our arguments inside the
Commission we look at Medicare margin, not at total margin. But then we really, in a sense, look at total margin as a way of justifying payment adequacy because it's really the payment rates outside of Medicare that allow us to come to the findings.

If you could go to page 10, Jack, slide 10. If you look at slide 10 in terms of access to care, volume of services, quality of care, access to capital, a lot of that is arguably driven by the higher payment rates in the private sector.

Now Arnie and others around the table might say we should also be looking at the payment rates in the private market, as opposed to Medicare. But I would argue that it's highly inconsistent for us to say let's just look at Medicare margins, which are projected to be more than 5 percent negative in the upcoming year, and then use the payment practices in the private sector which allow this to happen to say that access is good.

So I just find that highly inconsistent. I understand why we look at Medicare total margins, for the reasons that have been well articulated over the years. But then I don't think we should say that there's adequate
payment in the Medicare program. There aren't. I appreciate the fact that we're recommending a full update as a result, but I think it's hard to find that Medicare leads towards adequate payments because I think there's clear evidence that it does not.

Secondly, on the IME, I think having the recommendation -- I think I understood you, Craig, that it's going to be amended to say that concurrent with the implementation of the severity -- so I think with the severity adjustment system, which should have a positive effect on the hospitals that have higher acuity patients to be served, this is a fair and appropriate recommendation to make that have that kind of balance.

I do think in our ongoing discussion of the empirical factor and whether the payments are above the empirical factor, to constantly say that the payments are adjusted for the costs of residents is a little misleading. The costs are for the cost of a teaching hospital. We measure, as a proxy factor, the size and scale of a teaching program by looking at the number of residents. But we have a long history, both inside this Commission and in other forums, that the role of a teaching hospital is not just
measured by the number of residents. It's a proxy measure thereof.

I think the chapter does a good job of pointing out some of the other things in terms of anchoring regional care systems, providing standby capacity in terms of part of the issue in the last four or five years, terrorist attacks and so forth, being an anchor in a whole variety of ways to the care program of communities that teaching hospitals provide. So I do think there's a broader role that has been well established in policy, just like we have well established policy justifications for critical care hospitals and various provisions in rural care for policy exceptions to the empirical factor.

So I do think we should perhaps lighten up a little bit on the fact that it's just the cost of residents that is driving this empirical factor, that in fact there's other unspecified roles that the teaching hospitals play that drive this higher payment we make in IME.

But by and large I think the recommendations we have come up with are fair, balancing with the kind of concerns that the Commission has expressed over the course of the last few months. But I couldn't help but note that
we are highly inconsistent in the fact that we use total
margin to justify accuracy and then we deny that we use
total margin -- that we can look at the total margin at
other times.

DR. KANE: I had some questions in the way the
data was presented that I'm not quite sure I understand
what's going on. When you do on page 12 the overall
Medicare margins -- and you said that's for all lines of
business, inpatient and outpatient and then also any post-
acute or home health. But we're only recommending an update
for the inpatient and outpatient.

It would be helpful to me to not put the other
pieces in there if that's possible so we can separate --
because we're not recommending an update for the other
pieces of the business. I don't know if it's a huge
difference or not. It probably isn't huge but it's
confusing.

MR. ASHBY: Two responses to that, just to get on
the table. The inpatient margin is minus 0.9 and the
outpatient margin is minus 9.4. But the reason that we have
looked at the overall Medicare margin is because we don't
really have confidence that the measures of the individual
components are an accurate representation of those services. And to capture the interplay, we need to look at all of the services so that we can be confident that it's accurate at that level.

DR. KANE: I think we have that problem but this is useful to have the break down because -- I mean, this might suggest a differential update between in and out. Minus 0.9 is roughly a break even, versus the outpatient of minus 9.4. Granted, they can allocate overhead but there's a point where we have two separate programs and we're recommending updates on that basis. I just think it would be useful to keep it to the underlying detail.

The other question I had is if we're recommending a severity adjustment for the DRG system and we know that that is going to -- that's budget neutral, I assume. What would be the impact on the disparity between the teaching and non-teachings once you do that? Because we now have a 12 point spread. And if we don't ask to have a reduction in the IME, aren't we making the disparity even greater by doing the severity adjustment?

And I know there was another adjustment, or I'm not sure it was ever implemented, simultaneously around
reweighting based on costs rather than charges.

These all sort of came together. Do they all affect the disparity? What's the end result? It would be helpful to break that down as well, just so we understand what we're really doing here if disparities between non-teaching and teaching are important to keep an eye on.

My concern remains that when you do give a funded non-mandate such as the IME or the DSH or a tax exemption, you do create a competitive advantage to the ones who get it. So the disparity, even though it may not be an equity issue between the teaching and the non-teaching, it is a competitive issue and it really can upset certain markets pretty badly. You know which market I'm from, which is one of the most upset. But I think New York, California, it's not just an equity issue. When you just hand out money without an accountable piece for it, you can create competitive advantage and disadvantage. Some would view that as inequitable but I agree there's inequities across the board.

But I think we do want to keep track of these disparities, whatever we want to call them, and understand the impact of the policies that we recommend on that
disparity. Because in the real world we are creating
competitive advantage and disadvantage in some markets.

I think I'll stop there, but I just would like to keep some of these things more broken out than they are in this presentation, just so I understand them better.

MR. HACKBARTH: The other major question was the impact on teaching hospitals, severity adjustment, and other payment refinements. Do you want to address that, Craig?

MR. LISK: Severity adjustment by itself, keeping the rest of the payment system in place, would increase payments to teaching hospitals by a little more than 1 percentage point. It would reduce payments to other hospitals.

The other refinements overall, if we look at -- in this analysis we're looking at weights created with 2002 data, implemented on 2004 data, which is a little bit different than what Julian had presented earlier in the year. We see actually basically total payments about the same both for teaching hospitals and non-teaching hospitals, in terms of if you think of the full refinements the Commission recommended, you see teaching hospitals and non-teaching hospitals about the same.
DR. KANE: So no increase in the disparity with a reweight?

MR. LISK: About the same. There may be a few tenths difference, but I know on teaching hospitals, for instance, the difference with going to 2004 weights was basically a zero change within that, with all the refinements.

DR. KANE: Also then the last thing is given that we think that the hospitals that lose money on Medicare are losing money purposefully because they've increased their cost because they have payment-to-cost ratios in the private sector that allow that, is that kind of what you're getting at?

MR. ASHBY: I'm not sure I'd put in terms of doing it purposely, but they have some freedom to absorb a higher rate of cost increase because they do have the additional revenue coming in on the other side. That pattern is pretty consistent.

DR. KANE: So would it be helpful to look at the margins of what we would consider Medicare efficient hospitals, as opposed to the total? I want to get at Ralph's point a little bit, but I want to make it a little
The private sector has largely backed off from heavy-duty payment constraints ever since the late 90's. And I agree that you are incentivized to be more efficient if you can't just shove it over to the private pay. And when you can shove it over to the private pay, you're creating affordability issues.

It would be helpful to see the margin on the hospitals that do not have the opportunity to cost shift over to the private pay. Instead of saying -- what's the inpatient margin and the outpatient margin for those hospitals that can't cost shift? Because those are the efficient hospitals to whom we are trying to hold everybody to that standard. Those are the costs we're trying to cover.

MR. HACKBARTH: Let me leap in here and I'm not going to answer your question specifically but talk about this general issue, the significance of the Medicare margin for the update recommendation.

As I think I said at the last public meeting, over time in my mind, and I won't pretend to speak for the whole Commission here, but in my mind the margin figures have
become less important to what the right policy is over time. And I look at the declining Medicare margin for hospitals and like everybody else at one level it gives me a little bit of anxiety, and my stomach churns a little bit as I see it.

On the other hand, I think the real question for the Congress, not just for MedPAC, is what to do about cost trends. It our goal in setting updates to accommodate the underlying increase in costs and thus stabilize margins or hit some target margin? Or should the update be driven by the need to improve the efficiency of not just hospitals, but this applies to all Medicare providers, and force bluntly providers over time to change the cost trends and reduce the cost trends?

Now the task is complicated by the fact that in recent years, since the managed care backlash, private payment rates have become relatively generous. And that's due to a number of different factors. In some cases a factor is consolidation within the hospital market, and you've talked often about how that's an issue in Boston. In other cases, it's because of the design of health benefits programs and options with tight restrictive networks became
less popular and bigger networks became more popular. Now that pendulum is swinging back a bit now.

But the dynamics on the private side have changed. Lots of the flow of dollars into hospitals from the private side has become much more generous in the last five or six years than it was previously. And hospitals have said we've got the resources and we're going to spend them. It's a largely not-for-profit industry and they exist to spend the money, not distribute it as dividends to shareholders.

So when the revenues go up, predictably they will spend, whether it's on capital investment, expansion, new imaging facilities, more staff, whatever. They will spend it.

And so Medicare faces this problem that private payment policy is influencing hospital behavior and now it shows up as Medicare cost increases and Congress needs to decide how much of that to accommodate.

I don't think that in that complex world, dynamic ever-changing world, looking at a margin and saying well, the margin is at this level, therefore the right update figure is X, that there's some sort of formulaic response. I don't think there can be.
DR. KANE: I actually wasn't suggesting that there should be, but I do think both Ralph and the industry document that was faxed, FedExed, and handed to us today goes back and says well, look at the Medicare margins. And I think that the response should be to clarify that, that yes, there is a negative margin in effect on the outpatient side that's really negative. But perhaps we should clarify the fact that we feel the efficient provider, or the one that doesn't have the private pay cost shift available may have a better margin and make that argument. Just burying it in a broader number makes it harder to make that argument. It's really more of if that's one of the factors, let's clarify it for this sector because it can easily be buried in this minus 9 percent.

MR. HACKBARTH: In various ways, we have tried in the last couple of years to look at the industry not as a whole but rather in parts and how do hospitals in different situations respond? What happens with their cost trends, their average length of stay, their Medicare profitability? In fact, it's a complex situation. But a consistent factor is that hospitals that face more financial pressure through a combination of Medicare and what happens
on the private side tend to have lower cost increases. Many of the hospitals that are consistent losers financially tend to be in a situation where frankly they deserve to be losing. They've got low occupancy, they're not very competitive within their existing markets. There are the hospitals that are nearby alternatives to them. And I don't personally lose a lot of sleep over them.

DR. KANE: All I'm asking is if we could show the margin that way, as opposed to an overall, as a way to help people understand what you're saying.

DR. MILLER: I do want to jump into this for a second and just give you more of a mechanical answer.

So far everything that you've mentioned, with perhaps one exception, is presented in the chapter. And most of it was presented in the last meeting. A couple of things in the chapter, we do make the separate margins known in the chapter, and I believe that was presented in the last meeting. We also go through extensive discussion on this issue of cost and how it has an effect on different hospitals. We have an extensive discussion on the poor performers, the point that Glenn is making.

The only place that we haven't done exactly what
you've said is that when we talk about the poor performers, what we present are more things like their cost, their cost growth, their occupancy. It's the margin that sort of divides them into the groups that we look at. And that's the one piece of information that is somewhat different.

In this instance, and I just want other people to understand this. It's not that this information is in here. We also have to make a decision when we come up to this meeting to get down to 10 or 15 minutes to give you guys the time to talk. We tend to try not to repeat information that's gone through in the previous meeting.

But virtually everything you've said has either been presented or is in the chapter.

DR. HOLTZ-EAKIN: Glenn has anticipated a lot of what I was going to say, and said it better than I could. I've struggled with the process to come to this particular recommendation. In the way that I laid out my thinking the day has passed when the starting point can be accommodating what's gone on. So it's struck me as sensible to sort of think of market basket minus productivity as a benchmark against which you would begin weighing different factors. And the factors are the ones that the staff has
walked through. You look at access, which seems quite good. You look at services, which are increasing. You look at the quality of care, which is going up. Everything seems fine.

One of the things that struck me, in thinking through our job today, is that if this were the doctors that's all we'd know and we'd be done. And we'd say, okay, it's market basket minus productivity, things are in good shape, let's move on.

But in this case, we have this other thing called the margins. And now suddenly you have to figure out what these margins are, and it's fraught with all sorts of problems. First of all, there's the genuine measurement difficulties that make it difficult to isolate lines accurately. There is the difficulty that these are projected margins, and I want to emphasize that the projections are fraught with all sorts of uncertainty and can't pretend to weigh evenly with the facts.

And given that, do you want to use that to move you off the benchmark of market basket minus productivity? And I have some doubts about that. I have particular doubts because even if you bless the margins as accurate and bless the projections as perfect, the notion that you would just
drop any productivity adjustment whatsoever suggests that
drop any productivity adjustment whatsoever suggests that
these entities have no other way to accommodate these costs
drop any productivity adjustment whatsoever suggests that
than to just get more money in. Which means they're out of
drop any productivity adjustment whatsoever suggests that
internal opportunities to reinvent, reengineer, alter the
drop any productivity adjustment whatsoever suggests that
way they do their business to accommodate cost pressures.
drop any productivity adjustment whatsoever suggests that
And I think the presentations that have happened
drop any productivity adjustment whatsoever suggests that
this year suggest anything but that.
drop any productivity adjustment whatsoever suggests that
So it's a struggle to make that go away,
drop any productivity adjustment whatsoever suggests that
particularly relative to the kinds of standards of evidence
drop any productivity adjustment whatsoever suggests that
that are presented in other parts of the Commission's
drop any productivity adjustment whatsoever suggests that
business. And I think it is worth thinking hard about what
drop any productivity adjustment whatsoever suggests that
the role of the margins, particularly projected margins,
drop any productivity adjustment whatsoever suggests that
play in this discussion.
drop any productivity adjustment whatsoever suggests that

DR. WOLTER:  Just a couple things.

After about the third year of seeing your thesis,
After about the third year of seeing your thesis,
Jack and Craig, I've come to believe in some of it. The
Jack and Craig, I've come to believe in some of it. The
idea that in markets where there's less discipline there's
idea that in markets where there's less discipline there's
maybe a little relaxation of the ability to tackle costs.
maybe a little relaxation of the ability to tackle costs.
I've been somewhat skeptical because I've been worried that
I've been somewhat skeptical because I've been worried that
the other side of that coin is that there's cost shifting
the other side of that coin is that there's cost shifting
going into the private sector that's creating tremendous
going into the private sector that's creating tremendous
pressure there, and particularly in states like mine where
there are small businesses. That creates a very difficult situation.

So I think there's a balance to the thesis, and that is there are some legitimate cost issues. Whether that's nursing or other highly paid professionals or technology, some of those things are true issues. They're not easily controllable, I guess I would say, some of them. So we might have a little balance on that, although I certainly have, as I've said, to appreciate the work you've done on this.

Obviously the history of this, Doug, is that for a while we went on the philosophy that we wanted to cover the costs of an efficient provider. So that's the background in the years I've been on this Commission.

I am appreciating, though, that we've come to a point where we're trying to be more intellectually honest about the fact that the real issue might be what can we afford? And that we maybe are getting to a point in this program where we have to make decisions about what we can afford that aren't necessarily based on the existing cost structure. And I think that is a reasonable, as you outlined it, Glenn, issue that we need to start putting on
the table as we move forward. Although I certainly would
support the current recommendation when you look at the big
picture, I'll say that.

I also think this margin discussion again points
out the importance of specific tactics underneath the
umbrella of this. For example, much more aggressive DRG
reform, so that we blunt the incentive to drive volumes in
certain areas that really are driving up costs. I think
that's the more important topic almost, is to really push
those and other tactics.

I just wanted to mention on the technology
discussion more specifically, I'm a little worried that we
may need to be looking at the complexity of technology costs
a little bit more differently. I don't know that it's truly
logical to think that P4P will be a place where there's true
ROI for the costs of implementing clinical technology. It's
very expensive as an upfront cost and the ongoing operating
costs are significant.

I think the real issue there is it also does
involve almost a redeployment of human process. That's the
hardest part of it, much harder than implementing the
hardware and the software. And much of the gain once you do
that is actually not accruing to the health care system, per
se. It may be accruing to the insurer, the payer, or the
beneficiary, which is what we should be trying to do, of
course. But it's a more complex story than we're maybe
indicating in the current technology conversation.

And then on IME, I've come to appreciate both
sides of this discussion. I guess one of my worries is that
with what we need out of the academic medical centers in the
years ahead, given the significant workforce issues we're
going to have, given the needs that we're going to have to
train physicians differently, as Ron was talking about
earlier, we need to be very careful about underfunding that.

So what we're really wrestling with, it seems to
me, is how much of that can come out of the Medicare
program. I gather there have been past commissions that
have looked at academic medical center payment. And it does
seem to me this is a really important area in terms of a
strategic decision about how do we fund appropriate training
for the work force needs that we have ahead of us? Which I
think we're in trouble in terms of the physician
availability that's out there.

So I don't know how we put that back on the table.
We are dealing with a more specific issue about Medicare, but there is a bigger issue about how we make sure we have a strong training program in the academic medical centers.

And then again, I know we're going to start getting to it tomorrow, but the whole outpatient system really does need its own review. That's a fairly recent prospective payment program. The margins are fairly negative. Do we want to keep letting it sit like it is? Or is there maybe something about that that needs more attention?

And then my last question was it's not clear in the recommendation, I think it's clear in the text. But the implementation of the quality incentive program if this 1 percent came out, that would go to all hospitals? That's not just limited to the academic medical centers; is that correct?

MR. LISK: That is correct.

MS. BURKE: My compliments once again to the staff, who I think have done a great job overall in the chapter in describing a complicated set of questions. Let me say at the outset that in terms of the recommendations, I certainly have absolutely no issues at
all with the first recommendation.

With respect to the second, I certainly don't have any issue, and in fact strongly support the pressure being put on CMS to move with respect to the severity adjustment and the need for that. I am concerned about the sort of linkage. And I understand, I think Glenn has done a great job of trying to strike a balance here, the linkage to the issue of IME and I want to talk separately about the reduction in the IME. But I certainly have no issue with the severity and the need to do that and need to find the funds to do that, nor obviously do I have a concern about the recommendation with respect to the market basket. I strongly agree.

If I could, without sort of belaboring the issues that have come up before, but talk specifically about the IME adjustment, there is an underlying premise throughout the text. I mentioned it earlier and I'll sit down with the staff and go through it.

There is the use of the term equity and a suggestion that this is about equity, and the reason we're dealing with the IME adjustment is to create a more equitable distribution of funds.
There is the suggestion that it has gone off course in terms of its original intention. The staff have done a terrific job, I think, of listing the history and what the original intent was when we created the adjustment, and our desire to acknowledge those things that occurred in teaching hospitals that could be clearly defined -- and that is both with the direct medical education as well as with IME.

And then the sort of presumption or the expectation that there were other things that would occur in those institutions that might result in additional costs to the institutions that were less clearly defined.

One of the things that in the chapter the staff does, in fact, was to identify what some of those social related missions might well be. It is interesting, in going through those, in fact were one to look at them, the earlier parts of the chapter in a couple of cases in fact confirm that in fact those things are occurring.

One example, for example, are those standby services, burn, transparent and trauma. The chart earlier in the chapter clearly acknowledged that in fact they are present far more frequently in large teaching hospitals than
they are in other hospitals. There's a discussion about
other standby capacity that has become sadly increasing
important to us post-9/11 that are also readily available in
these large teaching hospitals.

The presumption or the suggestion is that the
extent to which we identify those as valuable social goals -
- and that includes the value of training physicians, as
Nick pointed out, the value of training really a broad array
of health care providers in these institutions is a social
goal and one that is of value to all of us not simply to the
Medicare population, that Medicare has made an explicit
commitment to doing that.

One might question whether or not going forward
that is the right mechanism. And that is certainly the
fundamental question, should Medicare in fact be uniquely
responsible for bearing this cost in a very specific way?
Or should it, in fact, be looked at as a broader social goal
that ought to be funded through an appropriations matter on
an annual basis? Or whether it should be done through some
other kind of entitlement program.

The staff have noted both of those things. The
fact of the matter is it is not. It has not been picked up
through the appropriations process. And I would argue, in fact, going forward that the possibility of that being consistently supported given the current pressures is unlikely.

Whether or not the creation of a new entitlement specifically to that activity -- and I'm setting aside for the moment the issues around uncompensated care, which I think is an important issue but not one I'm talking about currently -- whether or not it would be likely to be supported in that fashion. I think again, given the current environment, it is unlikely to be funded in that fashion going forward.

So the question for us is whether or not there is, in fact, a value in us in doing it, whether it is an appropriate expenditure for Medicare. And I would argue, in fact, that it is. It has been in the past. I think there are things that occur in those institutions. I worry a little bit about the point that Nancy raises, that this is inherently an anti-competitive move, that essentially we're benefitting these particular kinds of institutions. There are specific things that occur in those institutions absolutely that do not occur in other institutions and I
think they are, in fact, an important and valuable product. Whether it is the presence of these services, whether it is the training of health care professionals.

So again there are clearly differences of opinion among the Commission. I acknowledge that. My only concern is, as we look at the text, that we not suggest that this is about equity. It is about a fundamental question as to whether or not this is a responsibility for Medicare to bear. I would argue, in fact, that it is. And I worry about reducing the adjustment, in fact, will begin to harm those institutions that are doing it. In fact, there's an acknowledgment that the greatest impact in the reduction of the IME will be on the very large teaching facilities that, in fact, do predominantly provide these services as compared to some of the smaller ones that have fewer residents present.

But again, I'll be happy to work with the staff about those language issues and those sort of underlying presumptions that I think perhaps somewhat overstate the sort of equity issue perhaps more than they ought to be. But again, I certainly don't disagree with the market basket issues. I don't disagree with severity. But
I would strongly argue against a reduction in IME, for the reasons I suggest.

MS. DEPARLE: I was reminded when you brought it up a few minutes ago, the discussion about the increasing tension that you feel between continuing our long-standing practice of looking at each subsector of the health care industry and of Medicare payment both in a siloed fashion doing our analysis and not looking at the overall Medicare spending trends. We're looking at them, I guess, only in the context of sort of the context for Medicare spending and not really making a statement about it.

I think all of us, this summer at the retreat we discussed this as well. I think all of us feel the pressure, in my thinking about it, I do think the issue about what we can afford and the bigger picture of this whole program and what can beneficiaries afford needs to be on the table. We should put it there and we should have that discussion and perhaps with more vigor and robustness over the next couple of years. And I think we are raising it at every turn.

But I don't think -- my thinking about it is that it's not our role to try to address that issue. And I think
that is where you, at least for now, come out as well with
respect to each subsector in the context of our update
decisions.

There are some folks down the street who were
elected to do that. There some folks up on Capitol Hill who
were elected to do that. There's a gathering storm about
this entire issue, whether it's from the trigger in the MMA
to the President's recent proclamation that he's going to
balance the budget by 2012. So these issues are on the
table and I don't think it's our role to solve it, although
we may play some part in helping to shed some light on how
to solve it.

In that regard, I support the recommendation. I
thought it was balanced. I think it was my colleague, Nick,
who said at the last meeting that given all of the data that
has been shared with us by the staffs, if there were ever a
year for a full market basket update, this seems like it
would be it to me.

And also I think, though, that we don't want to
lose the emphasis on the other piece of this, which is huge.
It's huge to me to be sitting here with a recommendation on
a quality incentive payment program for hospitals. I think
we may have gotten somewhat -- because we spend so much time
talking about this in this group -- numb to the fact that
that is big news. That will be big news if that goes
forward and is implemented for hospitals and Medicare.

So I think what we come out with is a balanced
approach that both rewards hospitals for doing the right
thing but also moves us in the right direction.

DR. CASTELLANOS: I have a little problem in
really understanding and accepting a change in IME without
really looking at some of its ramifications. I think there
is a significant workforce problem now. I hope the
Commission will look at that next year, perhaps when we have
the retreat we can think of that as a problem that needs to
be looked at. But I'm seeing cracks now in my community.
As a practicing physician I see we have a workforce problem
now, not just in geriatrics or primary care but in several
of the surgical subspecialties. And I think we, as a
Commission, have a responsibility to continue to provide
access to care for the Medicare beneficiary.

I also have a problem when we cut back on these
funds of the educational value, as we discussed previously
with the SGR. This again is going to impact the future
education of the physicians in the communities.

I'm not against cutting back but I would hold it
with a lot of trepidation.

MR. HACKBARTH: Let me share some comments from
Karen and Arnie, and let me begin with Karen since one of
her points picks up on what Ron just said about workforce.

Karen asked me to say that she, too, is very
concerned about the future of the physician workforce and
health care staff more generally. She said that we've
tended to focus on primary care and whether there are going
to be enough primary care physicians. But she believes that
the issue is significantly broader than primary care and
that there are a number of other specialties where the
future looks pretty bleak based on the numbers that she's
seen.

So she thinks that in the not-too-distant future
this is an issue that MedPAC needs to grapple with more
directly.

Having said that, Karen said that she does support
the recommendation to reduce IME by 1 percent concurrent
with severity adjustment, although her preference would be
to allocate the money differently, to allocate it half to a
fund designed to encourage changes in medical education, as
Arnie has often advocated, and then half just back into the
base payment.

Arnie also supports the reduction in IME but he
would allocate all of it to medical education, changing
medical education.

Let me now just add a comment of my own on IME.
Because of my own personal work experience, I am quite
sympathetic to the very important mission that teaching
hospitals fulfill within the system. I had the opportunity
to work closely with some really great institutions, the
Brigham and Children's Hospital in Boston, in particular.
So I've got the utmost respect for the work that they do,
the contribution that they make.

Having said that, my perennial concern in my seven
years on MedPAC has been that the current IME system is
problematic from my perspective because there's no
accountability for what's produced. We're putting a lot of
money out there. I think Nancy used the term funded non-
mmandate or something like that. It's billions of dollars
for which there's no accountability. And that always has
concerned me, and it concerns me in a way more each year
given the greater sense of urgency that I feel about health care costs in general and the Medicare program in particular.

So what I would like to see is appropriate funding for these important institutions coupled with more accountability. I see this link to the severity adjustment as a very small, admittedly meager, step in that direction in the sense that one of the historical reasons for doubling the IME adjustment was teaching hospitals care for our sickest patients, and we've got to make sure that they are not financially damaged in the process of doing that.

And I agree with that, but there's a better way. There's a better way and that is to get on with the process of adjusting specifically for the severity of the patients treated. That will shift more money towards teaching hospitals.

And given the overall issues, the disparity in margins, whether you characterize it as inequity or not, there is a large disparity. I don't think now is the time to shift still more money to teaching hospitals. So this recommendation sort of says okay, let's establish appropriate payment for caring for really sick patients but
let's not shift still more money in our limited budget
towards the teaching hospitals.

MS. BURKE: Glenn, if I could just respond for a
minute, I don't disagree with a single thing that you've
said. I absolutely agree that we ought to be moving to a
system that, in fact, is sensitive to the actual acuity of
the patient and we ought to pay in that fashion. Separate
from the question of teaching hospitals, that is a
fundamental responsibility of the program that ought to be
dealt with.

I don't disagree with you, frankly, that the
industry has done a very poor job of documenting, and we
haven't frankly asked them to document how, in fact, these
funds are spent. And I don't disagree that there ought to
be far more accountability. Whether we could agree on those
things that we think they ought to be accountable for,
whether it is standby, whether it is the presence of certain
services.

The difficulty has been, I think. on our part from
failure to define what those things might be. On their part
failure to, in fact, define what it is that they're doing.
So I don't disagree that we ought to get there, we ought to
decide what it is that we think they ought to be spending
the money on if we choose to spend the money.

My concern is -- I think severity is the right way
to go. That is a piece of it. There will be teaching
hospitals who qualify for that, in fact, because they have a
higher acuity of patient. So I don't argue against that at
all.

And I don't fundamentally argue long-term about
getting to a situation where we agree on what it is that we
think ought to be paid for and that they ought to be
accountable for doing it. Whether it is an improvement in
the way they teach physicians and others, I absolutely
agree.

My concern is once the money is gone, the chances
of putting the money back in any near term if, in fact, we
would agree that there are certain kinds of things, always
becomes more complicated. Once it goes into the base, once
it goes into another delivery system, it is difficult to
recapture those funds.

And so my concern is simply not that maybe there
isn't a reduction that's appropriate. I wouldn't deny that.
And I wouldn't deny that the severity piece is one piece to
It will have the biggest impact on the largest teaching hospitals who, in fact, are doing the things that we at least vaguely articulated as appropriate. For example, these standby services, the presence of things like burn units, trauma units, and so forth.

My concern is they will get a piece of it back in severity. They won't certainly get all of it back, which makes sense because it's more widely distributed. But it's the failure to have articulated ultimately what should the policy be. I don't disagree that's the direction we ought to go. And if we were ready to go there, I'd be on board. My concern is the reduction in the absence of a clearly articulated long-term strategy. But I don't disagree at all with the direction you want to go.

DR. REISCHAUER: I agree with all of the recommendations that we are considering. But I have a hard time seeing how the IME recommendation has anything to do with workforce issues, although that keeps coming up. Do we honestly think that if we reduce by 1 percentage point the IME payment hospitals are going to train fewer physicians? We're still paying them more than the empirical amount. If
we were to go below the empirical amount, there might be
some adjustment. Do we think that by keeping the payment up
at its current level we're going to address the shortage of
certain specialties, gerontologists, general practitioners?
No, unless we become very prescriptive about what you can do
with this money.
So at this stage I think these are two issues that
are more or less disconnected and shouldn't enter into the
debate.
Just going forward as a warning for where we might
be next year when I guess we're going to consider workforce
issues, whenever I hear all of the discussion about
shortages, et cetera, et cetera, I am reminded by what Jack
Wennberg and Elliott Fisher have been saying which is there
is huge variations in the physician-to-population ratio
across the country. In those areas where there seem to be
tremendous numbers of physicians per person, there seem to
be a lot of usage of supply sensitive services which don't
seem to have too much impact on health outcomes.
And we want to keep that body of evidence in mind
at the same time we're considering what the projections look
like for the physician workforce going forward.
DR. CASTELLANOS: I'd just like to reply to the workforce issue. Bob, it's not an issue that they're going to cut back. We already have a shortage right now. We have a shortage in general surgeons. We have a shortage in vascular surgeons. And what we're not doing is increasing the programs and putting more people out.

We have the baby boomer population coming up and we're not preparing for it. By cutting back, the residency programs are not going to expand to the needs that are needed today, not the projected needs that are going to be needed with the baby boomers.

DR. HOLTZ-EAKIN: I just wanted a echo something that Nancy-Ann said which is, in looking at the update recommendation, as I said earlier, I have a hard time supporting it. The only way I can get to supporting it is if, in fact, it is really the case that this concurrent implementation of the quality incentive payment program is news and is emphasized. Because I think absent that it's hard to make the case that this is the right amount of money and that that really has to be a central part of the message.

MR. HACKBARTH: Let me just pick up on that. Here
again, I think I'm repeating something I said in the past
but I'll do it anyhow.

We've been recommending pay-for-performance now
for several years. We began with those areas of the program
where we thought that the opportunity was relatively easiest
in terms of clearly defined quality measures and the like.
And so our initial recommendations were to begin pay for
performance with Medicare Advantage, dialysis and hospitals.
Then, in subsequent iterations, we made similar
recommendations for post-acute providers and physicians.

What I fear is happening is that the movement has
slowed, maybe even to a halt, over the complexity of doing
pay for performance for physicians, which I think we noted
when we talked about physicians, that for a variety of
reasons it is perhaps the most complex area to do pay for
performance. The number of physicians, the relatively weak
information infrastructure, the degree of specialization and
the like.

Yet that seems to be the rate limiting step now in
the policy process. We can't do pay for performance for
anybody else until we figure out how to do it for
physicians. That doesn't make sense to me.
So I do see this as an opportunity to again reiterate that we think that there are relatively easier opportunities -- none of them is simple -- but there are easier opportunities than physicians, including hospitals, and it's now time to move on with that. And so I agree that that's an important message that we ought to emphasize in the text.

I think we are ready to vote now, so would you put the recommendations up?

On recommendation one, which is on uncompensated care data, all opposed to recommendation one? All in favor? Abstentions?

On recommendation two, all opposed? All in favor? Abstentions?

On recommendation three, all opposed? In favor? Abstentions?

DR. KANE: [off microphone] I just feel like we didn't get to talk about in and out and whether there should be a differential for in and out, and it all got bundled before. And I just don't feel we got a chance to really talk about it. But maybe it's just me being stuck on the fact that in and out are very different.
MR. HACKBARTH: So how would you like us to record your vote?

DR. KANE: [off microphone] I hate to make trouble but it's more than I --

MR. HACKBARTH: Making trouble is not one of the options I'm giving you. Yes, no, or abstain.

[Laughter.]

DR. KANE: [off microphone] I'll support it but I do feel I don't know yet what's going on. But I'll support it.

DR. REISCHAUER: Record Nancy's enthusiasm.

MR. HACKBARTH: We are ready for a brief public comment period, and we're running a little bit behind so I'd ask that you keep your comments even shorter than usual. Consider this a productivity adjustment.

Please identify yourself first. If somebody before you has made a comment similar to yours, please just say I support that comment as opposed to going on with it.

Any comments?

Okay, thank you. We will reconvene at 1:20.

[Whereupon, at 12:46 p.m., the meeting was recessed, to reconvene at 1:20 p.m. this same day.]
MR. HACKBARTH: We are ready to roll. Our first discussion is on dialysis.

MS. RAY: Good afternoon. During today's presentation we are going to review key information about the adequacy of Medicare's payments for dialysis services. You have seen most of this information during last month's meeting.

I will present a draft recommendation for you to consider about updating the composite rate for calendar year 2008. This will be my final presentation on this topic before the March report.

Before I start, I just want to remind you that we are discussing the care provided to about 320,000 dialysis patients in the U.S. Most of these patients are covered by Medicare. Thus, how Medicare pays for outpatient dialysis services is relevant to their care.

Reviewing information about beneficiaries' access to care. There was a net increase of 79 facilities between 2004 and 2005. There are about a total of 4,600 facilities in the United States. The number of dialysis stations is keeping pace with the growth of the patient population.
There is little change in the mix of patients providers treat. For example, the demographic and clinical characteristics of patients treated by freestanding facilities did not change between 2004 and 2005.

With respect to facilities that closed, some of what we found is intuitive. Facilities that close are more likely to be smaller and less profitable than those that remained in business. We see, however, that African-American and dual eligibles are over represented in facilities that closed compared to those that opened in 2005. However, the overall access appears to be good for these two patient groups because facilities closures are infrequent.

The draft chapter includes a strong statement that we will keep monitoring patient characteristics for the different provider types.

Moving on to the change in the volume of services, first we see that the growth in the number of dialysis treatments has kept pace with the growth in the patient population. However, the use of drugs increased between 2004 and 2005 more slowly than in previous years. For example, erythropoietin, which is the dominant drug of all
dialysis drugs, its dose per treatment remained about the same between 2004 and 2005. By contrast, it increased by 7 percent between 2003 and 2004. These changes in drug use are related to the MMA.

As mandated by the MMA, CMS lowered the drug payment rate for most dialysis drugs beginning in 2005. At the same time, the MMA shifted some of the excess drug profits to the composite rate. So as the drug payment fell, CMS increased the payment for the composite rate by about 8.7 percent through an add-on payment.

Reviewing information about dialysis quality, it is improving for some measures, the proportion of patients receiving adequate dialysis and patients with their anemia under control. Between 2000 and 2004, the share of patients receiving adequate dialysis increased by about 4 percentage points, from 91 percent in 2000 to 95 percent to 2004. The proportion of patients with their anemia under control showed even more improvement, increasing by 9 percentage points between 2000 and 2004, from 74 percent to 83 percent of all patients.

At the same time, there has been concern raised about the steadily rising erythropoietin dose per treatment.
This raises the concern about whether paying for drugs on a per unit basis promotes efficient behavior from providers. One policy option the Commission could think of evaluating in the future is bundling drugs as an interim step until CMS bundles both composite rate services and dialysis drugs, labs, and other commonly used services. A dialysis drug bundle might be one step towards addressing the potential incentive for overuse.

One quality measure, nutritional status, has showed little change over time. One strategy that Medicare might consider is collecting information about patients' nutritional status on hemodialysis claims. This type of information could be used in Medicare's quality improvement efforts. We don't collect this information for all patients like we do for patients' anemia status and dialysis adequacy.

CMS and researchers have shown how valuable this information is to monitor care, to pay for care and to try to improve care.

Looking at providers cost for composite rate services and dialysis drugs between 2004 and 2005, the cost per treatment fell by 5 percent. This decline is partly
related to the MMA reducing the payment rate for dialysis
drugs. As I just discussed, the MMA has slowed the increase
in the volume of drugs providers have furnished.

Here is the Medicare margin for both composite
rate services and dialysis drugs. It has increased since
2003. We project it to be 4.1 percent in 2007. Without the
auto-correction, we project it to be 1 percent in 2007.

There's a couple of points here to consider.

Drugs were still profitable in 2005 under Medicare's payment
policy, and that was average acquisition payment. Part of
the drug profit moved to the composite rate in 2005 and it
moved into the add-on payment. Costs for composite rate
services and drugs decreased between 2004 and 2005.
Providers received an update in 2005 and 2006 to the
composite rate and an update to the add-on payment in 2006
and 2007.

Finally, the 2007 margin projection also
incorporates the law just passed by Congress that increases
the composite rate by 1.6 percent beginning in April of
2007. For the first three months of 2007 the rate stays at
the 2006 level.

You can see here that the Medicare margin varies
by provider type. It was larger for the largest two chains, the large dialysis organizations, than for everybody else. This is partly due to the differences in drugs profitability between these provider groups. Even after holding patient case-mix constant, we find that the large dialysis organizations have costs significantly lower than other freestanding provider types.

So let's review our indicators of payment adequacy. Most are positive. Our analysis of beneficiary access is generally good, although we still continue to monitor access to care for specific patient groups like African-Americans and dual eligibles. Providers' capacity is increasing, as evidenced by the growth in dialysis stations. The volume of services, dialysis treatments and dialysis drugs is increasing. Dialysis drugs at a lower rate than in previous years but quality did not decline for two key measures, dialysis adequacy and anemia status.

Providers appear to have sufficient access to capital, as evidenced by the growth in the number of facilities and access to private capital for both large and small chains. Per unit cost growth declined between 2004 and 2005.
The second part of our update process is to consider cost changes in the payment year we are making a recommendation for, 2008. CMS's ESRD market basket projects that input prices will increase by 2.5 percent in 2008. As is the case with other provider groups, we consider the Commission's policy goal to create incentives for efficiency.

The draft recommendation is to update the composite rate by the market basket less the adjustment for productivity growth, that's 1.3 percent. So this recommendation would increase the composite rate by 1.2 percent. There is no provision in current law for an update.

So this would increase Medicare spending relative to the current law: $50 million to $250 million for one year and less than $1 billion over five years.

No effect on providers' ability to furnish care to beneficiaries is expected.

The Commission could couple the update recommendation with text in the chapter about implementing pay for performance for dialysis providers. We recommended a quality incentive program for facilities and physicians.
who treat dialysis patients in 2004. Quality incentives are feasible for facilities and physicians because accepted measures are available, systems are in place to collect data, data are available to risk adjust measures, and providers can improve upon measures.

As a future topic, Commissioners could consider evaluating alternative measures including dialysis adequacy, anemia status, nutritional status, the use of home dialysis, the use of recommended types of vascular access, hospitalization rate, and mortality rate.

Underneath the recommendation, we can also include text about distributional concerns concerning the current payment method. We already have raised the first two items in our June 2005 report, where we recommended that the Congress combine the composite rate and the add-on payment and eliminate differences in paying for composite rate services between hospital and freestanding facilities.

We could also raise a concern about the MMA requirement that CMS update the add-on payment based on the growth in drug expenditures. Updating based on such an approach is not consistent with the Commission's approach
for developing payment policy. And updating the add-on
payment would not be necessary if Medicare would bundle both
composite rate services and drugs together, which is, of
course, another Commission recommendation.

I look forward to your discussion.

MR. HACKBARTH: Questions? Comments?

DR. KANE: Why did Congress not have any update in
current law? Was that just random or was there some intent?

DR. MILLER: We can say it, we don't know.

MS. RAY: We don't know.

MR. HACKBARTH: This is an issue that Nancy-Ann
and I have often talk about. Nancy Kane asked about why
dialysis is different from other providers, where there is
an update included in current law.

MS. DePARLE: Mark, do you know? I don't know. I
remember being shocked when I found this out in 1997 or so.
I didn't know it and I don't know why.

MR. HACKBARTH: So understanding the origins is
beyond our ability. The question has come up in recent
years whether that ought to be changed and whether dialysis
ought to be given sort of a baseline update written into
current law. And that issue Nancy-Ann and I have discussed. We've discussed at some Commission meetings, as I recall as well.

My own view, for what it's worth, is that if anything, what I'd went like to do is move all of the other providers to the position that dialysis facilities are. In fact, our basic approach to updates is each year you ought to take a look at the adequacy of rates and not have built into the baseline a hospital market basket or any other particular number. You ought to start from zero. And they ought to be treated equitably, but they ought to be treated equitably in that way as opposed to moving dialysis into what is, to me, a more problematic approach.

The good news, I suppose, from the perspective of dialysis providers, has been that MedPAC has been pretty consistent in recommending updates in the rates and we've been one of their few allies in some years of advocating update in rates when other people have been inclined to freeze them.

So that's an inadequate answer to your question.

Others?

DR. CASTELLANOS: Just a comment on one of the
indicators for nutritional status. It's my understanding that if you're in chronic renal failure but not on dialysis they'll pay for a nutritional consult. But once you go on dialysis, CMS doesn't pay for it. Maybe a more appropriate thing would be to suggest that CMS also pay for nutritional consults on patients on dialysis.

MS. RAY: You are correct, in the nutritional counseling, that Medicare covers it before you're on dialysis.

Part of the composite rate bundle, my understanding, is the requirement for a dietitian and dietary counseling of patients within the facility. Now whether or not there should be even more could be a future topic for the Commission.

MS. DePARLE: That was a point that I was going to make because I think I said this last month too, or maybe I'm just repeating from a prior month. But I think we have made this point about the nutritional inadequacy and that it's not getting better a number of times. I would like to see us make a stronger recommendation on it. Maybe it's the one that Ron suggests.

It just doesn't seem like it's getting better. I
think one of the reasons is the reimbursement.

MS. BURKE: I agree, but it would seem to me that -- for someone who's in dialysis and the extent to which we're paying a composite rate, a well-run facility who is looking at the long-term needs of the patient ought to incorporate that into essentially the basic services. So if they're not doing it, rather than create an external payment outside of that it would seem to me we ought to find a way to put pressure on by saying you're not going to get an update or something if you don't begin to address these nutritional issues.

I'd keep it as part of it, because you don't want to begin to break out payments again. The difference is if you're in dialysis you're in an organized system of delivery. If you're not, essentially if you're in renal failure but not yet dialyzed, arguably you need that additional sort of opportunity to purchase those services. But I would strongly encourage us to find a way within the composite rate to encourage facilities to do this.

MR. HACKBARTH: What I hear you saying, Sheila, is that given that for years now we've been advocating more bundling, not less, to recommend a separate additional
payment may not be strategically the right thing.

MS. BURKE: Particularly if we're assuming that a well run facility ought to be providing a fairly --

DR. REISCHAUER: We've made a recommendation about pay for performance here, and obviously that would be component of performance. So in a way, if the recommendation is followed, it's taken care of.

MS. DePARLE: I agree but I think we have to be clear about what the composite rate covers when it comes to nutritional supplements, et cetera.

MS. BURKE: It's dietary consultation and...

MS. RAY: It covers a dietitian and dietary counseling. My understanding is it does not cover the oral supplements, the oral drinks.

MS. DePARLE: So I'm not necessarily saying do a separate add-on. That doesn't seem like the way to go. But I do think it should be part of the composite rate.

MR. HACKBARTH: Others?

Okay. I guess we are ready to do our vote on draft recommendation one.

All those opposed? In favor? Abstain?

Thank you.
MS. DePARLE: I feel like I've made this point four years in a row. On the nutritional piece, we keep complaining about it every year. But I do think -- we don't have a recommendation yet again, and it just seems a little like a broken record. If we think there's something that can should be done, it seems to me we should be making a recommendation.

I voted for the recommendation on the update because I agree with it, but I'm a little uncomfortable in continuing to make these same observations every year and not say more.

Perhaps, Bob, you think it's just covered in our pay for performance recommendations, but I don't think it is.

DR. REISCHAUER: [off microphone] I'm saying that's a mechanism to make sure it happens. If the composite doesn't include appropriate resources for this particular aspect, it should be beefed up so that's the case.

MR. HACKBARTH: So what I hear is Nancy saying that built into the initial composite rate was counseling on diet but not included was payment for therapy for
nutritional issues. And you are advocating, as I understand it Nancy-Ann, that we make some payment adjustment in the facility rate to cover the added cost of therapy and not just counseling?

MS. DePARLE: Yes. I would say that the composite rate should be adjusted. This may be some of several ways in which we think it should be adjusted. We've certainly talked about others. But the composite rate should be adjusted to cover those costs because we've raised this -- I've been on the Commission now four years I guess. This is my fifth cycle. And we've raised it every year and yet we don't ever make a recommendation about it and nothing seems to happen.

MR. HACKBARTH: I apologize for that. I would be reluctant just, without knowing what those costs are, to vote on a recommendation right now but I will make the commitment that we will have a specific recommendation next year. We'll look at it and discuss it as a Commission and decide what to do.

Any other questions or comments about dialysis?

MS. BURKE: Just following up on Nancy-Ann's point for just a second. I wonder if there's something that ought
to be said -- I mean the text talks about the absence of the nutritional supplement piece. It also references the anti-kickback statute issues which will clearly quickly come into play.

I wonder if there's anything that we ought to add to the text in that section that talks about the Commission remains concerned and would like to begin to collect the information necessary to establish this for purposes of establishing a pay for performance and incorporating this into the rate.

Because one of the issues will be gathering the information that allow us to figure out what is the adjustment that needs to be made, how you link it so you don't end up with everybody suddenly getting nutritional supplements. But that it's linked to some quality indicators that can be tracked, and that we put on and clearly send the message we want the data collected, we want to be able to do this.

That may be another further step to strengthen this.

MR. HACKBARTH: I wouldn't have a problem with that sort of discussion of the issue in the text.
Before we leave dialysis, I haven't really focused on the language in that draft chapter but I'd like to make sure that the language about bundling is strong and placed at a very visible place in the chapter. I really do think it's time to move ahead with a broader bundle for dialysis, both for financial incentive reasons and for clinical reasons. So I just want to underline that.

Thank you very much, Nancy

Next is the physician update analysis. Cristina, I just forgot to mention that Karen Borman did give me a comment here. She wanted to say that she supports the recommendation of market basket minus productivity for the update and that we urge Congress and CMS to move ahead with bundling.

She also encourages us to investigate the issue of other dialysis methods and why they haven't been more widely used, home dialysis. So that's an interest of hers.

DR. MILLER: Actually, at lunch we were talking about whether to go ahead and present the slide that you have on how the payment system works and I said wait for it come up on question. It came up on question during lunch, so actually why don't you go ahead and work it right in.
MS. BOCCUTI: So I'll be flipping back and forth in slides, so bear with me. I'll warn you when I'm doing that.

But even before we get to what Mark just brought up with the new law that just passed, I just want to answer some questions from our good discussion last month that came up. The first one I have here, Nancy-Ann, you asked about comparing the CAHPS-MA, the health plan CAHPS, with our beneficiary survey. It is, of course, more challenging than it might appear. I talked with Carlos Zarabozo, and he's looked into that and looked into the whole CAHPS-MA survey quite in-depth.

He was telling me how it's challenging to compare the two because the questions are different. We ask, in our beneficiary survey, about finding a new specialist or a new primary provider. But in the CAHPS survey they ask about seeing one. It's enough of a difference, I think, in substance to not be able to compare the two questions very well.

But with that said, I will mention there is, as you know, increased enrollment in MA. And as I mentioned, there is no way in our survey to distinguish between
Medicare fee-for-service beneficiaries and those in MA, just
due to the restraints of getting a survey in time. You have
to ask a lot of questions.

To some degree, if MA enrollment is increasing,
then there are going to be more MA beneficiaries in the
survey. And when a beneficiary goes into an MA newly, they
have a higher likelihood of needing to encounter the
circumstance where they have to find a new physician due to
the plan having some sort of preferred provider constraint
or something like that.

So there is a possibility that an increase in MA
enrollment may be affecting what we picked up, which was at
least at that time of the survey somewhat of a dip in access
to specialists. That came from a good discussion with
Carlos. You could probably talk with him a little bit more
if you wanted to get into that.

Bob, you asked about comparing the CAHPS fee-for-
service, so that's a different survey but a lot of the same
questions, to our volume. So you said on the questions
about finding a specialist or getting an appointment how
does that compare to the number of services the
beneficiaries are actually getting?
It's not a straightforward one-to-one. The maps don't look exactly the same. And GAO has looked at that kind of question pretty carefully with maps than I drew from.

In the areas where there is low use, like Montana and Wyoming, Colorado, Minnesota, Iowa, they do tend to have lower rates of reporting problems, getting an appointment, seeing a specialist, et cetera. But it's not consistent. You can't draw that line or that relationship across all of the country. In fact, a lot of the areas that have low use are pretty middle of the road in terms of reporting access problems.

There was even areas with high use, like Florida and Alabama, that don't have access problems. The beneficiaries aren't reporting that. But in California, I noticed that there is some high use areas that also have high access concerns. And that's where you think oh, people are using the services a lot and they can't get the appointments. I think that's what we were sort of thinking was happening but it's a lot more mixed.

Bill, you and Sheila and Karen were asking a bit about the mammography, but you asked specifically about the
percent decline. Because if you recall, there were some declines in quality measures for mammography. I put this in the chapter but I'll just say it just went down between 1 and 3 percentage points. I think I said about one, so it depends on the measure.

But you also asked about whether those measures were high to begin with, in which case the decline is just more likely because if you're so high where do you have to go? They are not that high. I think they were between 61 and 77 percent, depending on the measure. So I think two out of the three don't even meet our two-thirds threshold on what we would expect because these are measures that they should really be doing. Consensus is built that these are the things that are pretty much necessary care.

Ron, you mentioned about making sure that we include not just in our workforce -- we had a small discussion which was mostly about what we hoped to be able to do, not just mentioning that the baby boomers are the patients but they're also the physicians. So we made sure that that was in there. And so there's a retirement issue that might come up as well.

And then Jay, you asked about examining by region
the physician survey that we did. Unfortunately, while I do have information about where the physicians are practicing, the survey sample was not drawn to be regionally representative. It's drawn to be nationally representative. So we really can't draw conclusions based on specific areas because the population doesn't support that.

And finally, Mitra, you asked about comparing -- we had a list on the physicians reporting that they were very concerned about specific aspects. For example, the one I think that came up was about reimbursement levels. You had said -- because for some questions we looked at the type of physician, proceduralists, non-proceduralists, and surgeons, and how does that vary when you're looking at reimbursement?

When you break that down, surgeons were the most likely to say that they were extremely concerned, proceduralists -- and those are like cardiologists, ophthalmologists, and radiation oncologists, those were the next most likely to say they were very concerned. Non-proceduralists, like primary care providers, they were the least likely to say that they were extremely concerned.

And note that these are not just Medicare. The
same rank order happens with private, non-HMO reimbursement levels.

So it was all this side of the room, interesting.

So if there's any follow-up to that, I can probably -- okay.

Now I'm going to continue on with the presentation. The first thing I'm going to do is talk about the recent law that just passed, the Tax Relief and Health Care Act of 2006. Then I'm going to review indicators of payment adequacy for physician services that I presented previously. I'm going to go over the latest estimates of cost changes expected in 2008. And then present the draft recommendation for your review and discussion.

I'm going to discuss four provisions in the Tax Relief and Health Care Act that relate specifically to physician payment. The first provision has to do with the conversion factor for 2007. Specifically, the law allows the 5 percent cut imposed by the SGR to go into effect but then offsets it with a 5 percent bonus outside of the SGR formula. So this results in a 2007 conversion factor that is the same that it was in 2006.

Note that this provision relates only to the
conversion factor, so payments for some services will increase or decrease because of RVU changes that also go into effect.

The second provision extends the floor to the work GPCI through 2007. This floor was originally imposed by the MMA and was set to expire at the end of 2006. It increases the work GPCIs in low-cost areas, so it primarily affects rural physicians, raising their work index to a floor of 1.0.

A third provision in the Act establishes the opportunity for physicians to gain a 1.5 percent bonus on all covered services they furnish between July 1st and December 31st, 2007. To obtain this bonus, physicians must report quality measures for 80 percent of the services for which CMS will have established measures with some adjustments based on the share of services the physician provided that actually have measures. CMS will calculate the bonuses from physician claims, sum them up, and pay eligible professionals in one lump sum in 2008.

The fourth provision in the law establishes a fund of $1.35 billion to be directed towards 2008 physician payment. The allocation mechanism is at the Secretary's
discretion but it must be directed towards physician payment or quality and it should be fully allocated in 2008, to the extent possible.

I'm going to now go forward and show you a picture of what I just said to illustrate how these all fit together. So go back to the original, when I talked about the conversion factor. When you look at the slide, these red lines show the conversion factor before the act. So you can see in 2006 about $38. In 2007, and you can see it jumps down 5 percent, rounded, of course.

Then when you go to the next piece of legislation that I mentioned, which is what I'll call the 2007 conversion factor bonus, that's where the SGR still goes into effect technically, but on top of that there is a 5 percent bonus. That's the yellow dotted line. So it effectively leaves the conversion factor for 2007 to be equal or equating to what it was in 2006. So you can see that bump up.

Then on top of that you see the blue 1.5 percent increase. I put that on the 2007 because it refers to the 2007 services that they provided, and that's the quality reporting bonus that they will get if they report the
measures adequately. They will get the money in 2008, but it refers to the 2007 services.

What's not on here was the work GPCI information but it complicates things to put that on here, so you'll remember that.

So then if you're looking at 2008, you may be hearing in media reports that there's a 10 percent decline in 2008. Realize that it's a 10 percent decline if you're taking it from what the conversion factor will be effectively in 2007 or is, but it's a 5 percent because it's simply adhering to the conversion factor that the SGR had originally intended. So it's a 5 percent decline from the year before if the conversion factor had stayed the same.

Am I explaining that okay? So that's that demonstration of where that 10 percent that you may be hearing comes from.

This gray dotted line is that fund, that $1.35 billion fund, that is not as yet allocated in the sense of its determined where it's going to be and how it's going to be allocated. But it's there in 2008, so I put it in the slide. But it's not going to be part of the scoring of an update unless the Secretary determines that it will be part
of that.

And then this has it all together.

MR. HACKBARTH: What might be helpful is to explain why this approach of allowing the SGR to technically take effect and then having a separate payment to offset it, why that approach was used.

MS. BOCCUTI: Let me go back to the final tally of all that and that might come into play here. This is the spending and financing of it.

So one of the reasons the SGR is still in effect, I'm not going to really postulate to the reasons, but the effect of keeping the SGR cut essentially in place is that you are finally pulling out of that cumulative hole. Whereas, if you delayed the SGR from being implemented, then you increase the cumulative hole. So here you're finally eating away at the hole but you're pulling in new money. You're pulling in new money from the SMI Part B Trust Fund to pay for that bonus. So instead of being able to score it like it's going to be repaid within 10 years, that's no longer the case with this provision.

You can see on the slide it costs out. This is from CBO scores -- the different provisions.
DR. MILLER: Just a slightly different way of saying that is if you do this you can give an update, for example in 2007, but it doesn't extend the length of time that negative updates are assumed into the baseline. You said that, but that's just a different way to think about it.

MS. BURKE: Cristina, just so I understand the reference to the term new money, this is money coming out of the existing SMI Trust Fund, so it is simply a further draw down of the Trust Fund which will translate into what percentage of the program is now going to be funded out of the Trust Fund? It's a plus to the Trust Fund draw down. Not new money, it's simply out of --

MS. BOCCUTI: Right, the money that is in the trust fund so it draws that trust fund down.

To say what share it is of the Trust fund, I would first like to Rachel.

DR. REISCHAUER: But the Trust Fund consists of money transferred from general revenues and premiums contributed by beneficiaries, so this is an example of Doug's Congress will have to face the pain; right?

MS. DePARLE: Here they did, in a way. They took
$5 billion or whatever the number was.

MS. BURKE: The reason I want to understand it is what impact does it have on the premium?

MS. BOCCUTI: It will increase the premium, but not in 2007, not until 2008, but they have determined --

MS. BURKE: It will be calculated on the basis of the 2007 cost, so it will translate into the 2007 rate increase.

MS. BOCCUTI: Into the 2008 rate.

MS. BURKE: Into the 2008 rather, it will be calculated for the premium increase.

MS. BOCCUTI: Right. They determined that in 2007 it's been set already.

MR. HACKBARTH: So you said at the outset this doesn't contribute to the hole actually in budget accounting. Because you allow the 5 percent cut to occur, you're actually climbing out of the hole. But that assumes that then next year that you go to the conversion factor, which is 10 percent below the current prevailing rates. If you don't do that, then you jump back down into the bottom of the hole again; right?

MS. BOCCUTI: Yes.
MR. HACKBARTH: Okay, having sorted that out, let's move on to the rest of the presentation.

DR. MILLER: Actually, just one clarification.

DR. HOLTZ-EAKIN: Must the Secretary spend all $3.5 billion in 2008?

MS. BOCCUTI: The Secretary is directed to spend, to the extent possible, all the money in 2008. But the extent possible, or feasible is the word that they said.

DR. REISCHAUER: It's an election year.

MS. BOCCUTI: So CBO scored it so they spent about 90 percent of it in 2008 and there is other language to say that they have to do an actuarial projection to make sure that they're not going to spend more than that.

MS. BURKE: But that's also funded by Part B?

MS. BOCCUTI: Correct, it's funded by Part B, which is 25 percent beneficiary premiums and 75 percent general revenue.

DR. MILLER: The only reason you were using language new money is in a sense it's not SGR money. It's different money from the Part B Trust Fund, is sort of what we're trying to stumble around and say here.

MR. HACKBARTH: I think we've dwelled on this long
enough.

MS. BOCCUTI: It's important. It's new information and they were doing this while we were meeting last time.

MR. HACKBARTH: And actually, I thought you did a very good job of explaining it.

MS. BOCCUTI: Thank you Now I'm going to review what we talked about last month, so a lot of this information won't be new.

We started with the physician survey MedPAC sponsored. As you may recall from our last meeting, our survey found that the majority of physicians, or 96 percent of them, accept at least some new Medicare fee-for-service patients and 80 percent accept either all or most.

Acceptance of new Medicare fee-for-service patients compares very favorably to Medicaid and HMO patients but it's a little lower than for private non-HMO patients.

For comparison, I want to mention that these numbers are very similar to two other national surveys, namely the NAMCS and the HSC physician surveys, both of which however only go through 2005.
Regarding referral difficulty, physicians more frequently reported a little more difficulty referring Medicare fee-for-service patients than private non-HMO patients, 7 and 3 percent respectively. But referring HMO or Medicaid patients appeared more difficult than Medicare fee-for-service.

On our survey many physicians reported recent changes to their practice to increase revenue or streamline costs. Specifically, they've increased the number of patients they see, expanded in-office testing and imaging, and changed the mix of personnel that they have in their practice.

Our survey also asks physicians about the factors that affect their individual compensation. Most, about 80 percent, reported that their own productivity, which is typically measured by their service volume and even RVUs, was a very important determinant of compensation. Other factors, including patient satisfaction, quality measures, and resource use, were considerably less likely to be as important to their compensation.

These findings are generally consistent with those reported by HSC last week in an issue brief, but HSC's
survey was conducted in 2004 and 2005, so it's little bit older.

Turning to the beneficiary surveys, taken from several of the studies, one of which is ours, most beneficiaries report small or no problems scheduling appointments and finding physicians. Finding new specialists continues to be easier than primary care physicians, but we're monitoring a recent rise in reported problems accessing specialists. Transitioning beneficiaries, such as those who have recently moved to an area or switched to Medicare fee-for-service, are more likely to experience problems finding a new physician, especially in some markets. And Medicare beneficiaries report similar access to physicians as do privately insured individuals age 50 to 64.

Quickly, I'll review the other indicators that you've seen before, and all of these come from claims analyses. We found that the number of physicians billing Medicare has kept pace with Medicare enrollment. This held true even when we separated physicians by the size of their Medicare caseload. Also, participation and assignment rates remain high.
We also found that the difference between Medicare and private fees, averaged across all types of services and areas, has steadied over the last several years. Previous research by HSC has found that in areas where Medicare fees are closer to private fees beneficiary access is not measurably better than in areas where the fee differential is greater. This suggests that other factors, such as local health system developments, may influence beneficiary access as much or more than Medicare payment levels.

We saw continued growth in the use of physician services per beneficiary. Across all services per capita volume grew about 5.5 percent between 2004 and 2005. As in previous years, imaging grew the most, it grew about 8.7 percent, but the category of non-major procedures was close behind. E&M and major procedures did not grow as quickly.

We looked at quality care measures for ambulatory care, focusing on two general measures: ones that captured the use of clinically necessary services and ones that captured rates of potentially avoidable hospitalizations. We found that on most of these indicators rates were either stable or improved from 2003.

In sum, our adequacy analysis from available data
suggests that beneficiaries are able to access physician services.

Now for the second part of our update framework, changes in costs for 2008. The latest forecast for input price inflation is an increase of 3 percent. These forecasts are revised quarterly so this number was revised downward by three-tenths of a percentage point since I show them to you last month. The other factor that we considered in our input cost analysis is productivity growth. Our analysis of trends in multifactor productivity suggests a goal of 1.3 percent.

The SGR allows for price changes by incorporating the MEI into the formula, as you know. But for the update, CMS uses historic rather than projected MEIs. So the MEI that they use in their update for 2007 was 2.0.

So here is the draft recommendation for you to review. The Congress should update payments for physician services by the projected change in input prices less expected productivity for 2008.

Spending implications, they would increase Medicare spending by greater than $2 billion in one year and greater than $10 billion in five years. These numbers
reflect a comparison to current law, which continues to call
for a cut in 2008 which would lead to cumulative impacts if
that cut were averted.

In terms of beneficiary and provider implications,
this recommendation would increase beneficiary cost sharing
and would help maintain current supply of and access to
physicians.

I have a couple of more slides here. These are
additional comments to include in the chapter following the
recommendation.

The first point is that rapid volume increases for
some services may signal that Medicare's payment for those
services is too high relative to the cost of furnishing
them, if physicians or their staff are able to perform them
considerably more quickly than they did when these services
were first introduced. Consequently, physicians can
increase their volume of these procedures with little change
in the number of hours they work, making them more
profitable and creating financial incentives for physicians
to furnish them over services that may be less profitable.

On the slide I mention work RVUs but other parts
of the RVUs, like the practice expense, could also be a
factor. Staff are examining this issue as well. So in general, if you dig into the RVUs, you'll see several reasons why services have differential profit levels that could be affecting their provision.

So beneficiary access to less profitable services and the professionals who furnish them may be threatened if providers avoid furnishing them relative to more profitable services.

So in the future, the Secretary could play a lead role in identifying and correcting such misvalued services by conducting analyses that calculate changes in the productivity of individual services. Such analyses could begin by examining specialties that show rapid volume increases per physician over a given time period. Volume calculations would need to take into account changes in the number of physicians furnishing the service to Medicare beneficiaries and the hours those physicians worked.

Despite the additional funds provided for physician services in 2008 through the recent legislation we just discussed, the Commission is concerned -- and I'm going on to the second bullet -- that future consecutive annual cuts would threaten beneficiary access to physician
services, particularly primary care services.

Finally, we reference the SGR report in reiterating that ideally Medicare's physician payment system would include incentives for physicians to provide better quality of care, coordinate care across settings and medical conditions, and use resources judiciously.

Thank you.

MR. HACKBARTH: Comments?

DR. HOLTZ-EAKIN: Cristina, I have a question. When you said the bottom line on the spending implications, if you go back to that last graph you showed. You have the gray area. Is your spending implication from the top of a gray area, $2 billion on top of that? Or is it from the red bar for 2008.

MS. BOCCUTI: Spending implication of the recommendation?

DR. HOLTZ-EAKIN: Yes, for 2008.

MS. BOCCUTI: We're doing for 2008. It compares it to the red line.

DR. HOLTZ-EAKIN: But we also know they're going to get another $1.3 billion.

MS. BOCCUTI: Right, we don't know how, at all,
that will be allocated.

DR. HOLTZ-EAKIN: So my question is does the
Commission think that matters?

MR. HACKBARTH: Matters in terms of the update
recommendation.

DR. CROSSON: I really liked the question and
answer thing as we started out. So I thought maybe I would
kick off this side of the table with another series.

If you could go to slide eight for a second, and
go back to the physician survey again. Those issues that
physicians considered very determinations of compensation.

In the text, because I just looked back over it, you talk
about that difference between the productivity and the other
three elements as a function of payment methodology in the
sense that physicians who were prepaid tended to identify
the three at the bottom more frequently.

Is there also enough data to look at that from a
structural point of view? In other words, is there a
relationship between those three and the structural form of
practice that the physicians are in, or not?

MS. BOCCUTI: Structural meaning like the size of
their groups?
DR. CROSSON: The size of their groups.

MS. BOCCUTI: We do have some of that information on group size but a lot didn't answer that question. So whether their level of capitation in their revenues is what I discussed in the chapter. But I'll look back and see -- we asked some more questions about their group, but I'm less confident that we can make a distinguishing remark.

DR. CROSSON: Would capitation also include being paid by salary in the way you're using that term?

MS. BOCCUTI: No, it's about the revenue of the office. The individual compensation is a different kind of question.

DR. CROSSON: Of the office?

MS. BOCCUTI: The revenue coming into the office.

DR. CASTELLANOS: Just some observations. Just on this slide, I think this supports what Nick was saying this morning on the top part. You'll see that 50 percent of the doctors in this survey brought things into their office to increase their revenue.

And this is what's happening in the real world.

I'm a practicing physician. I'm a small businessman. When I lose money on something, I have to look for other avenues
of income, not different from any other business.

You're saying this, and this is really what's happening in the real world. I'm surprised it's just 50 percent.

Can we go to the slide just before that, slide seven? I made this comment last time. What really bothers me on this whole slide is something that we don't deal with. It's called Medicaid. As you can see that, I have a hard time -- we're the only group of urologists in my area, in the five county area, that accepts that program. We do it really for a social basis. We certainly don't do it economically. But this is what's happening in the real world.

Physicians are not dealing with patients always from an altruistic viewpoint. Sometimes you have to look at it from an economical viewpoint. This is just a reality of life and I just wanted to mention that.

I guess the real issue that I wanted to bring up and hopefully we can also discuss this at the retreat, is I don't understand productivity as it applies to a physician. I really don't understand that and I would like that not to be brought up now but perhaps we can discuss that in detail
at one of our sessions next year.

DR. WOLTER: I was going to make the same observation. There certainly would be some evidence in the survey of some of the issues that we talked about this morning. One could argue that these kind of innovations, if you want to use the word, into the office practice would occur anyway, although I suspect that this sense of looming cuts certainly is a driver of motivation to some degree.

And it wouldn't show up in the survey, of course, but I would add that really the rapid expansion of hospital/physician joint ventures is another part of what's going on here that we really haven't talked about very much.

I wanted to mention also, just to reiterate something from this morning, there may be some need to think about investing more in some aspects of physician reimbursement. I don't know where that fits into our conversation, not in the overall update I'm sure. But if you were to look at the need to have better chronic disease management or some of the medical home ideas, are we going to have enough internists to help manage care in a more coordinated way in the future, these are some issues that are worthy of discussion although they aren't necessarily
I'd like to just bring up again, because I'm so very, very worried about it, I think that the mixing up of measures for every physician specialty with the update is taking us in a dangerous direction. I think you summarized it very well this morning, Glenn, we're kind of at a rate-limiting point in where pay-for-performance can go because we're struggling with how to apply it to physicians because it is so much more difficult with so many of them, so many different specialties, lack of infrastructure.

In my view, even the IOM report if I'm remembering, Bob, that you were just part of, recommended being voluntary for a while with physicians because of some of these issues. And yet we're now kind of headed in a different track, which I am afraid could derail pay for performance if it goes badly.

So if we could start thinking about some recommendations that would create some focus in the early years on pay for performance and making sure there's synergy between some of the physician reporting and hospital reporting, which would mean it might be more limited to which physicians we start with, but it could really create a
lot of value. I think it could have a higher chance of
success and it could help us deal with some of the low
hanging fruit in these early years.

But we're kind of in, I would say, a dangerous
time in the development of pay for performance because the
mindset is we need to have a measure for every doctor in
order for us to do payment. And that's probably going to
get us in really big trouble.

MR. DURENBERGER: My question has already been
brought up by Ron and it deals with productivity. I bring
this up periodically because we seem to talk about it as
efficiency and things like that.

But when I think I first expressed it was in the
early days of prospective payment system, and I'm quite sure
what is ophthalmic surgery, when the technology began to
reduce the time and a lot of other factors, prices came
down. And I never knew exactly who figured out how the
prices came down to what.

So one of my questions is do we already have built
into the system -- and I'm trying to get at least three
questions from this side for next time, as opposed to only
two over there.
But do we already have built into the CMS system a way in which to accomplish some of the things that are on page 25 of the paper, I think alluded to it?

But the second one, as related to that, came to me reading a little interview in the New York Times last week of Clay Christensen, who is the Tipping Point guy. And he's talking about productivity, and he uses several examples, including Permanente and so forth. But in a more specific example is like MinuteClinic, which originated in Minnesota and eventually got sold for $270 billion to somebody, simply because they identified eight procedures that used to be done in some primary care physicians' office at X number of dollars, which could be done for $38 each if you had the Cub Food stores or Safeway or whatever your local grocery store, cum pharmacy, happens to be.

It suggested to me that people like Christensen and others will be raising on our screen generally, and you can see it in communities in which many of us operate, the opportunities for taking a lot of the things that are being done, whether it's on the technology side, the technology intensive side like I referred to earlier and we referred to here, or it's on the primary care side, and say if it's
access, if it's affordability and so forth that you're looking for, how long do we have to wait for the physician community itself to create a more productive way of delivering services? Or do we have to continue to create the MinuteClinics or the so-called disruptive technologies in order to get it done?

So I want to just add that dimension to the analysis of productivity because it's such an important part of how much of our money should we be spending via Part B on physician spending.

MS. BOCCUTI: In response to your first question about the process for seeing what is being done more quickly now than it used to be --

MR. DURENBERGER: Can't it wait until next time?

MS. BOCCUTI: Okay, Dave, you asked about... Recall the RUC process. Now that's every five years. What we discussed to include in the chapter this year around the recommendation is for the Secretary to perhaps take more of a lead on identifying these services that can be done quicker now or less expensively because of equipment and supply issues. If the Secretary could take a lead role in identifying and perhaps potentially
automatically correcting these efficiency gains that are
learned over time, then maybe we could move forward more
quickly.

But the process that's currently in place, and
that's just for the work, is the RUC Committee. And there's
other PE examinations, but they're slower.

So I think you're exactly bringing up what we're
bringing up in the chapter, too.

And then the MinuteClinic, yes, I see the
connection that you're making. I think also, with the
MinuteClinic, I read that article, too. And I note that it
was bounded by state policy issues about whether nurses
could write prescriptions or not. But also those were
specifically ones that don't need follow-up, so it's not as
applicable to Medicare patients. These were strep throat
and those kind of things. Pediatrics, I think, where a high
component of the MinuteClinic. But your point is well taken
and perhaps you all want to comment on that.

MS. BURKE: Cristina, could I just do a follow-up
question to Dave's question?

Remind me. We had a very lengthy discussion as I
recall, and I've now forgotten the time frame, around the
RUC process and a whole discussion around what occurred, what got on the table, how it on the table.

The reference in the chapter is relatively brief, just that the Secretary ought to be more active in identifying things.

I wonder if there's any value in reflecting back on that conversation. There were concerns about what was brought up, the frequency with which those items that were identified were ones where there was an uptick not an adjustment, that the predominant -- as I recall, I don't remember the number, but the large majority of issues that were raised were all about how we had to increase rather than decrease the modifiers to these particular diagnoses or these particular categories of activities.

And I wonder if there's any value in adding to that section of the chapter a little more substance to our concern about the need to evaluate and become much more aggressive in evaluating what it is that goes on the table, what gets evaluated, who sets the agenda and, again reflecting back on that earlier conversation, I just don't recall -- I think it was earlier this year or last year, rather.
MS. BOCCUTI: I think I cross-reference it in the chapter but I can easily add a more full discussion, drawing directly from what we punished before.

MS. BURKE: Great.

MR. HACKBARTH: I was going to pick up on that point on Karen Borman's behalf. Karen had several comments that she wanted me to offer and one of them does pertain to this issue.

Point number one is that Karen is concerned about the overall RBRVS system. In fact, the way she put it was that she would like to sign on with some of Bill Scanlon's previous comments about RBRVS requiring some investment, and maybe some fundamental rethinking. Karen's way of putting it was that conceptually we have this system that is designed to base our unit payments on the inputs that go into producing the service, whether it's physician work or practice expense or professional liability and that is legitimate as far as it goes.

But she said from her perspective there are other factors that also ought to be included in setting a proper price for services. One would be the value of the service, and the second would be to assure adequate supply of the
service. In a competitive marketplace it's not necessarily just looking at the input costs but ultimately generating sufficient supply in order to meet legitimate needs for valued services.

So she's got some deep reservations about the basic conceptual structure that all we ought to be doing is looking at input costs in setting physician fees.

She also said that she would like to associate herself with Nick's comments about pay for performance for physicians. She shares Nick's concern that we're just sort of running off in all directions with an unfocused approach that is not likely to be productive and could be very expensive for physicians and CMS to do and the combination of those two things just create on a lot of disillusionment with pay for performance and set it back, as opposed to advance it.

A third comment that she had was she wanted to remind people that for at least some services the current payment levels, she said, are at or below 1989 levels for those particular services. And maybe that was by design in some cases, that was part of the rethinking done with RBRVS, that the old charge structure led to inappropriately high
payments for some services. But she said she thinks that people sometimes lose sight of the fact of how dramatic the payment changes have been in unit prices and that some of these are very low compared to where they used to be.

So those are Karen's comments. Let me just sort of add a little bit to one of those.

I wanted to touch on this productivity issue for a second, that Cristina talked about, and the idea that the unit prices ought to be adjusted based on an assessment of improved productivity which may not be equal across all physician services and may be greater in some than in others.

There's a lot about that concept that needs to be thought through, worked out, to make it an operational idea. I like the idea of including some reference to it, for this reason.

One of the SGR options that we were asked to look at was to have a formulaic system that adjusted rates by type of service. So the rapidly growing stuff would be squeezed more than the slow-growing stuff. I understand the motivation for that, one of them being a concern about primary care being squeezed along with, say imaging.
I think that there are a number of different ways that you might get at that issue. One is a big formulaic system, SGR-like system. But another is an ongoing review of the relative values of the sort that Cristina described.

So my goal in putting that in this chapter is to basically create a placeholder and say if that is your policy concern SGR isn't the only available mechanism to get there. There may be other tools that we can develop for the annual update process and the updating of the RVUs that also address that problem.

DR. KANE: I just had a question about the $1.35 billion that Congress has set aside for 2008-2008, somewhere in there. Will we have a chance to talk about how we'd like to spend that? Or is that going to -- how is that process going to work out? Because that could be an opportunity to pay for care coordination or get started on some of the pay for performance. Are we going to have a chance to talk about that?

MR. HACKBARTH: That goes back to Doug's question earlier. One way to look at it is well, this is another $1.35 billion to be spent in 2008. Maybe that ought to affect the update recommendation for 2008. It supplements
the pool of dollars available.

Another way to think about it is the way that you described, that maybe it ought to be thought of separately from the update but we ought to think about how it ought to be distributed. Those questions are on the table.

DR. REISCHAUER: Remember, we're putting 1.5 percentage points out there to reward quality in 2007 that disappears. And we've created an appetite. So already there is, in a sense, a use for this resource if you think that initiative has had a positive impact.

DR. HOLTZ-EAKIN: But there's no guarantee that's where it's going to go.

DR. REISCHAUER: I know there isn't. I'm not saying that we shouldn't speak about it. But we shouldn't speak about it as if there are no legitimate claims if we think the 1.5 percent is a legitimate claim in 2007.

DR. SCANLON: I have a question. Is our update applying to a conversion factor for 2008 that is 10 percent less than the conversion factor in 2006?

MR. HACKBARTH: I was afraid you would ask that.

Logically, that would be the prevailing conversion factor which, to me, might put this in a whole different
light. If, in fact, rates were cut by 10 percent, then MEI minus productivity might no longer be the right number.

Which is why I was afraid you would ask that. Personally, I doubt that's going to happen, but technically that would be the base from which you're working.

MS. BURKE: In that context, Glenn, perhaps -- I mean, one could argue it probably won't happen. But whether or not we ought to put in some language, some caveat, that suggest we make this recommendation on the assumption that -- or something that suggests that if, in fact, we're that much farther in the hole it's a whole different conversation, arguably.

MR. HACKBARTH: I suppose we could do that in the context of the discussion that Cristina referred to, our historic concern has been that dramatic cuts in physician payment could ultimately affect access to care and it might fall disproportionately on some types of physicians. So we could align it with that point and say that the basis for this discussion assumes that there is not going to be a 10 percent cut in 2008, and if there were...

DR. HOLTZ-EAKIN: Can I suggest that at least to
me it makes sense to have a different formulation, which is
this recommendation is based on the notion that we have
adequate access to care, quality of care, that the metrics
that went into this recommendation were not dollar jump off
points or anything that has to do with a dollar value for
the conversion. It has to do with the quality of the
beneficiaries' treatment in the program. And that that has
to be assured -- not any dollar figure -- in order for the
recommendation to be executed as written three
I don't want to write something that says if you
do 10 percent then we can't make this recommendation. If
you tell me that access is as we envisioned when we made the
recommendation, quality is as we envisioned when we made the
recommendation, then yes, go ahead, no matter what the
particular numbers are. But those are two very different
things.

MR. HACKBARTH: I understand the distinction
you're making, but then it means that we need to speculate
on whether, in fact, access would be the same after a 10
percent cut as it is today. I wouldn't want to speculate on
that.

So what we can say is that our existing --
DR. HOLTZ-EAKIN: I don't think so. I think we're just saying these are the conditions under which we made the recommendations; right?

MR. HACKBARTH: And access is adequate at a conversion factor of 38, but not 10 percent lower.

DR. HOLTZ-EAKIN: We don't know that.

MS. BURKE: That's what we're doing it on, today.

MR. HACKBARTH: Just follow your own logic.

DR. HOLTZ-EAKIN: We don't know what it would be at 10 percent lower. We didn't go to check. That's my point.

MR. HACKBARTH: There's literally no way of knowing.

DR. HOLTZ-EAKIN: Right, but we don't know what they're going to do, either. So I don't understand why we're going to speculate on access and not speculate on what they'll do. Just give the conditions for the recommendation.

MS. BURKE: I think those are the conditions, as we know them today. They could change, in which case we'd want to revisit it. I agree with you, you don't want to presume it would not stay the same or stay the same, but
we're making it on the basis of certain understandings today.

DR. HOLTZ-EAKIN: So can I ask a different question, which is is our recommendation inclusive or exclusive of the $1.35 billion? If the money is there, the money will be spent.

DR. MILLER: Just to be clear from a technical point of view, all of this was going on when we were talking about it.

DR. HOLTZ-EAKIN: I understand.

DR. MILLER: So the answer to your question, technically and directly, is that it was exclusive. It assumes that the second step in her minus five chart is going into place. And to the exchange that you're having now, we're always in this very situation that you describe, which we are describing the environment as it exists on the day that we put the surveys out to ask about access and did the data analysis, et cetera, et cetera. And so that's the situation that we're in.

So I think the question that you've put on the table is one of two things, and there may be a middle ground for everybody to gravitate to. I'm not 100 percent sure.
But if we assumed it was really the minus five and it's actually not quite minus five, there's another $1.3 billion there that we didn't taken into account, you are in part asking should we have a different recommendation than the one that we've currently put on the table, market basket minus productivity.

Or alternatively we could say the recommendation is based on the baseline path and the information that we currently have, which is how it was constructed. And we now are aware of this new pot of money. And this is where some people seem to be headed.

And if you have feelings about how that money should be, it shouldn't necessarily be across the board to every physician -- and I suspect there's probably a lot of people who feel that way -- then maybe we should say something in the text about what we think at least directionally ought to happen to those dollars.

Is that too far out of line? That's what I sort of felt like people were beginning to --

MS. BURKE: I would argue -- I think I understand where Doug might be headed. Or where Doug is not headed.

We don't know how the $1.3 billion will be spent.
I think to make a recommendation on an adjustment assuming how that would be spent would not be wise. I think to make a comment on how we might hope they would think about spending the money I think would be consistent with at least some of what I'm hearing, which is that you might do for some kind of quality related -- if you're going to spend it, here's ways to do it.

But I think to make a recommendation on an update based on all of a sudden there's a new $1.3 billion, I think could quickly turn on us if, in fact, the $1.3 billion all goes to something that is unrelated to payment updates. We will have, I think, avoided the responsibility we have to make a recommendation specifically relating to the update. But we could certainly say if you're going to spend $1.3 billion, here's things you ought to think about spending it for, quality or reporting or whatever it happens to be.

DR. KANE: When will we have a chance to talk about the $1.3 billion, if not now? That's sort of what I originally thought I was asking. Is this the time to talk about it, or is another opportunity to get a shot at it where we actually get a chance to think about it and then
make a recommendation? I just couldn't tell where in the cycle we got a chance to say something else.

DR. SCANLON: I'll start by apologizing for raising the minus 10 percent.

But let me say I think we're not in the business here of writing the mathematical formula for increasing payment rates. What this recommendation does is expresses a sentiment. And the sentiment is that we really think that physician prices in 2008 should be roughly kept in line in real terms by taking into account inflation. And that because I think that maybe prices are overvalued or because there are productivity gains that are possible, we'd like to make a deduction from that.

If the Congress takes this recommendation as it's written, there is a lot of latitude in terms of what it actually does. It can consider the $1.3 billion and think about changing -- they have to write the mathematical formula. They can change that mathematical formula so that the combination of the $1.3 billion and what they do in 2007 gets them to this point.

I'm fully supportive of this, but it's a sentiment. It's not a formula, in my mind. Because we
can't sort all of this out. There's chaos in terms of these conversion rates as they move over time. And we would be speculating, we would be creating all kinds of contingencies like we mean this if...

And I think that's not a good use of our time.

DR. HOLTZ-EAKIN: Bill, would this be consistent with that sentiment? I'm just trying to figure this out.

The Congress should update payments for physician services inclusive of the physician fund by the projected change in input prices less expected productivity. Go figure out how to do it.

I said inclusive of the physician fund. Who cares where they take it, if that's the sentiment, that there's going to be money from somewhere, somehow defined, here we go.

DR. SCANLON: I'm thinking that what we're really aiming it is the 2007 level versus the 2008 level. I think we're not saying that the 2008 level should be inflation plus $1.3 billion above inflation. That's what Doug is making explicit.

MR. HACKBARTH: I think there's two distinct issues that Doug has raised. One is the 10 percent cut.
And then the second is how do we include the $1.35 billion in the update. The first one is easier, to me, than the second one.

We deal with the first one simply by including clear language that says that all of the access data, et cetera, is based on a certain level of spending. And so we're basing on our recommendations on what is known not what is so unknown. And we're not -- be very explicit, we're not speculating about what access would look like if there were, in fact, to be a 10 percent cut. We're talking about the updates off the prevailing level of actual spending, the actual conversion factors.

I think we can work out that issue relatively simply.

I suspect that there may be a division of opinion about the second issue, whether to say that our update recommendation nets out the $1.35 billion or maybe in additional. What I hear Sheila saying is we don't know how that money is going to be allocated. Therefore, to say we're just going to net it out.

DR. HOLTZ-EAKIN: Just to be clear, I thought we established, it will be spent.
MS. BURKE: No, the language, as I understand it, says to the extent practical or feasible. That to me, in Congress word, means there's enormous flexibility. What is and what is not determined to be feasible is in the eye of the beholder.

I don't think we know for a fact. The presumption is yes, but we don't know that for a fact, that all that money will be spent in 2007 or 2008. I don't think. I don't know that. Maybe we do, but that isn't how I thought I heard you describe it.

MS. BOCCUTI: I guess I would say I'm not as much in question that it will be spent in 2008. That isn't as much a question for me in my discussions with folks at CBO. It's whether or not it's going to be used as an update fund that's more in question. There's a quality component that could be part of it. It could be used for many different ways. And to assume that it's going to be attached to the conversion factor again, I think is what is a little bit more in question.

MR. HACKBARTH: Just to pursue that a little bit further, if it's as an update, then it goes to all physicians, it effects the conversion factor. It could be
that by 2008 the Secretary has seen the wisdom of Nick's recommendation, which is rather than trying to make this available to all physicians for reporting data, that we want to use it in a very targeted way, in which case it might have a very different distributive impact, the $1.35 billion and put your update decision in a different light.

I guess I'm with Sheila, that just saying well, our update recommendation is net of the $1.35 billion, seems a little bit simplistic to me, not that I have a great solution. These are good questions and not easy to answer.

DR. REISCHAUER: But with respect to hospitals, we're saying here's an update but take a percentage off it and put it into this quality pool and we don't know how it's going to get distributed. And in a sense, we're taking something away from all hospitals and then redistributing it to others.

And this is no different from that. We don't know that it's for good purposes, that it's going to be --

MS. BURKE: Bob, at least as I understood the hospital piece, we explicitly stated the expectation that they would create a severity adjustment. Admittedly, we don't know how the severity adjustment will be structured
but it's very explicit.

DR. REISCHAUER: That was for the IME money.

MS. BURKE: Right, the 1 percent.

DR. REISCHAUER: But we were also saying in the update we were going to take a percentage point out of that for the quality thing.

MS. BURKE: For the quality indicators. In this case, is there any direction on how this money is to be spent, this $1.3 billion? What are the terms?

MS. BOCCUTI: It has to go towards physician payment but that could include quality initiatives or the update. It has to be in some way related to physicians or the physician payment system. But that's about as much direction that there is. And that it be used in 2008 to the extent feasible.

MR. HACKBARTH: Nick has been waiting patiently so let's do him. Then I want to try to sum up where I think we are and agree on a next step.

DR. WOLTER: On the $1.3 billion, I can see the logic of whether that should be part of the update or not. But in a way, we're back into this tension between global economic allocation and what are the appropriate strategies
that would be the best use of the money. That's what I see
the tension as right here.

I would say, Bob, there are extremely big
differences in how this is going to unfold in the physician
world from the hospital world, because 1 or 2 percent to a
hospital is a very large number, in terms of the percentage
of their ultimate end of the day operating margin. 1.5
percent to a physician, based on their percentage of
Medicare business, may not cover the costs of hiring the RN
to do the chart abstraction. It may not cover anywhere near
the cost of trying to get going with IT to make it easier to
do the numbers.

I think we're into an interesting experiment here
as to whether 1.5 percent to a small physician group is
going to create any incentive whatsoever. Which is kind of
back to the point that we're really at an interesting
crossroads with pay for performance in the physician world.

My concern about rolling it into the update is
that it almost, by the very nature of doing that, is going
to have the effect of making it impossible to really get to
the discussion at least of our focus strategies may be of
more value than more diffuse strategies. I really worry
1 about that.
2 I would also like to see us get into the text that
3 there are some who are concerned that broad measures for
4 every specialty as part of payment may not be as effective
5 in the physician world as starting with more focused
6 strategies in high volume high cost areas where there's
7 synergy with some of the hospital measures.
8 I don't see anybody saying that right now in this
9 town and it should at least be on the table for
10 conversation.
11 Maybe this isn't our decision. Maybe it's CMS and
12 the AQA and the HQA group and the IOM. I don't know where
13 it's going to ultimately end up where some of these
14 decisions get refereed by the appropriate experts. But
15 there is a body of knowledge around clinical process
16 improvement and how to do it and how hard it is to do, but
17 right now we're on this rush to add measures to everybody to
18 solve certain payment problems and it's not being informed
19 by appropriate clinical process improvement skills sets.
20 That's why I really worry about how this might
21 unfold.
22 DR. CROSSON: Just a quick point on your first
point. Not this, but the 10 percent.

In this situation this year, to make it clear what Bill said the intent was of what we're doing, would it makes sense to add some language to the recommendation, for example to say Congress should update payments for physician services in relationship to actual 2007 payment rates by the projected change in input prices?

DR. REISCHAUER: That's what we're doing. We're not making a change off of the projected baseline for 2008. We're saying how should things change from 2007 to 2008. The cost of it will be the difference between that recommendation and the baseline as it exists with the 10 percent, so it will be a humongous amount of money.

MR. HACKBARTH: So Jay is suggesting that we alter the language in the recommendation itself to make that point. Does anybody have any objection to that?

So we can redraft it to reflect that.

On the issue of the $1.35 billion, I think Bob and others are right that consistent with our past logic about the funding of pay for performance, if this $1.35 billion is a potential pay for performance pot, it ought to come out of the update and be deducted from it.
Yet I hear some real reservations from Sheila and Nick about that approach. I, for one, would like to think a little bit more through that issue and talk to some of the rest of you about that. I don't want to do it more now because I think like we're spinning our wheels a little bit and we're already behind. We're going to be really far behind.

So let us come back tomorrow morning with the recommendation language revised, as Jay suggested, and then a proposal on how to proceed with the $1.35 billion, if that's okay.

DR. REISCHAUER: I shared Nick's concerns and reservations. The $1.35 billion has been, in a sense, authorized and appropriated. It's there. What it's going to be used for has not yet been determined. So we can't imagine that it doesn't exist. It exists more than anything else.

MR. HACKBARTH: But I think Nick has a point that, given that it is there, there is a certain imperative that says well let's try to make it available to everybody but saying we'll pay it out based on some reporting requirement for everything that will still be another step down an
unfocused pay for performance path.

I am Mr. Pay For Performance. I am a believer in it. But I must confess that I, too, am concerned about the physician piece in particular and whether there's strategic thinking around the approach of how to get this done effectively. I don't want to just throw another stick on that fire that leads further down a mistaken path.

MS. BURKE: Glenn, in anticipation of tomorrow's discussion, it would certainly be helpful to me to understand if there was any context at the time that this was proposed and agreed to, if there's any legislative history or language that suggests that this was in lieu or in addition to what was anticipated in terms of update, if there is an language or any discussion. I don't know what occurred at the time.

But to the extent we can find out whether there was any conversation or anything in the language surrounding the debate or the provision, that would certainly be helpful. Whether it was their expectations that this would be used in a particular way or in lieu of what was otherwise going to be anticipated in terms of an update. That would at least help me think about it.
MR. HACKBARTH: I'd like to move ahead now and
we'll come back tomorrow morning with some specific
proposals there.

Next up is skilled nursing facilities.

Before you start Kathryn, just a schedule update.

What we're going to do, tomorrow we're schedule to start at
9:00. We're going to move that up to 8:30 to accommodate
this discussion.

Now we're ready to move on.

MS. LINEHAN: This presentation will summarize
what you heard last month to inform your update
recommendations for skilled nursing facilities for 2008.

Just for variety, unlike Cristina, I've embedded
the answers to your questions into my presentation for you
to find.

DR. REISCHAUER: Will you identify which of us
you're answering?

MS. LINEHAN: No. I'm just going to point.

[Laughter.]

MS. LINEHAN: To review briefly, our indicators of
SNF payment adequacy are generally positive but quality has
declined. Overall, the supply of providers remains stable
in 2006. The most recent data show a net decrease of 0.1 percent in 2006.

Beneficiaries generally have ready access to SNF care. The OIG found in 2004 -- that's the latest year they did this study -- that Medicare benes appear to have little or no delay in accessing SNF services, especially if they need rehabilitation therapies. Beneficiaries with certain conditions, though, may experience delays that mean they stay longer in the hospital. The IG reported that Medicare patients were harder to place if they need IV antibiotics or expensive drugs, vent care, or have behavior problems. This is consistent with earlier findings by the IG and the GAO about services that have been identified as being underpaid by the SNF payment system.

Volume, as measured by total days and total admissions, increased between 2004 and 2005. I updated the volume numbers in your paper to be consistent with the time series we've used in previous years. Specifically, we see days increased 6 percent and admissions were up 5 percent. Spending was up 8 percent in 2005.

Volume growth was not even across RUGs. Case-mix continues to shift toward a greater share of higher
intensity rehab RUG days and a lower share of lower intensity not-rehab RUG days.

Our two measures of SNF quality show that between 2000 and 2004 quality has been going down. Average facility rates of discharge to the community declined and average facility rates of potentially avoidable re-hospitalizations increased. These are risk-adjusted measures that are measured within 100 days of admission to the SNF.

There was a question last time about whether a change in policy whereby the program pays to hold a bed for a patient who is rehospitalized. I think the thinking was that a change in this policy could change a facility's incentives to rehospitalize.

I looked into this and found that Medicare doesn't have a bed hold payment policy. It's a Medicaid policy and it varies by state. Since we're looking at patients under a Medicare stay, a change in a state's bed hold policy is not likely a major driver in the national rate of change in quality for Medicare patients.

But if there is an additional question on this, I'm happy to take it and try to track down the answer.

Finally, providers in the nursing home sector have
access to capital. Medicaid is the predominant payer of nursing facility care but because Medicare is generally a better payer analysts told us that Medicare's share and payments enhance a nursing home provider's access to capital.

For-profit chains report new acquisitions and construction financed by debt. The National Investment Center reports good loan volume and performance in this sector. And analysts we interviewed report several factors that make this sector appealing to investors, including a stable reimbursement environment, better than expected payment under RUG refinements, improving state fiscal situations removing the threat of Medicaid cuts, and SNFs being positioned to be the low-cost post-acute care provider for Medicare beneficiaries.

Now turning to margins, in fiscal year 2005 the aggregate Medicare margin for freestanding SNFs, which are about 92 percent of all SNFs, was 13 percent. We continue to see some variation across facilities and differences by facility type. Margins for rural facilities continue to be higher than those for urban facilities and they are higher in for-profit than nonprofit facilities, which we have seen
since the beginning of the PPS.

Based on 2005 cost report data we estimate that the 2007 aggregate Medicare margin for freestanding SNFs is 11 percent. This estimated margin is a function of payment changes that increased payments, including a full market basket update in 2006 and 2007, and changes due to RUG refinements, and changes that reduced payments including the elimination of temporary payment add-ons and a change to bad debt reimbursement.

This brings us to the update recommendation we discussed in December, which is to eliminate the SNF update for fiscal year 2008. Current law provides for a full market basket update and the most recent estimate is 3.1 percent in 2008. Providers should be able to accommodate cost increases next year without an increase in the base rate.

The spending implications are a reduction in Medicare spending relative to current law from between $250 million to $750 million for fiscal year 2008 and $1 billion to $5 billion over five years.

This should have no effect on providers' ability to furnish care to Medicare beneficiaries.
Finally, to come back to an issue that came up last month and has come up many times in our payment adequacy discussions for skilled nursing facilities, hospital-based SNFs have negative aggregate margins. They were minus 85 percent in 2005. The reason for hospital-based SNFs' higher costs are unclear and likely multiple and vary by provider.

One of these reasons could be allocation of overhead from the facility to the SNF. Hospital-based SNFs may also have higher cost structures which could be a function of different practice patterns. They may also treat different patients than freestanding nursing homes. For example, we know that they have more patients in extensive services if it's a non-rehab RUG group that freestanding SNFs. But again, this varies by facility.

Underlying all of these potential explanations about higher costs is whether the higher costs of hospital-based SNFs result in better quality in the facility.

Another important question for the program is the comparative cost and quality of an episode, by which I mean inpatient and post-acute care. That includes a hospital-based versus a freestanding SNF stay. Is the hospital-based
SNF stay a substitute for acute care or a substitute for freestanding SNF care?

Evidence suggests that hospitals decisions about SNF operations are not solely driven by the profitability of the SNF, but on how their SNF fits into the broader context of the hospital's primary function as acute care providers. In other words, they look across the episode to decide whether and how a SNF fits into their operation.

On site visits with hospital-based SNFs, we learned that those that have remained opened described operating different models with respect to selecting their SNF patient population. Hospital-based SNFs allowed hospitals to short their inpatient length of stay by transferring patients more quickly to their hospital-based SNFs compared with transfers to freestanding SNFs. Some hospital-based SNFs reported taking patients that they cannot place with freestanding facilities. The hospital-based SNF allows the hospital to receive an additional payment for the episode, since the hospital is paid per stay for the inpatient care.

Consistent with the kind of broader look at the episode of care, our analysis that Craig Lisk did of direct
costs of hospital-based SNF care found that while hospitals
have a negative fully allocated margin over the entire
inpatient and post-acute episode, the direct cost margin for
the inpatient and SNF stay together is about zero.

While hospitals would like to make a profit on
each stay, if they can cover the direct costs for these
complex cases, they have an incentive to care for these
patients. These data suggest that hospitals with SNFs are
covering the direct costs for the episode.

The SNF payment system does need to be improved to
more accurately pay for medically complex patients, such as
those using IV drug regimens and respiratory therapy.
Studies have found these patients to be less financially
desirable than rehab patients, which hospitals and SNFs told
us are their most profitable cases. But medically complex
patients are treated in all types of SNFs, so the payment
system should be improved to better account for these
patients' costs regardless of the type of facility that
treats them.

Creating different base rates for hospital-based
and freestanding SNFs moves payment policy in the direction
of payment based on facility type. This is counter to the
Commission's broad goal of a payment system that bases payment on patient needs and characteristics regardless of the setting.

CMS is beginning the work to examine assessment and payment across post-acute settings. Other payment policy changes, such as improving the accuracy of the case-mix system or paying for quality, are consistent with the Commissions goals to pay for necessary care delivered efficiently regardless of the setting without creating payment differences based on facility label.

This concludes my presentation and I'll take any questions you have.

MS. BURKE: This is terrific, Kathryn. There were a couple of questions that I had in terms of the quality indicators in this continuing issue and trying to understand the differences between the hospital-based facilities and the freestanding.

In the discussions, I was just looking back to see if I could find it and I didn't but I may just have missed it.

In the discussions around rehospitalization and the extent to which we can look at the avoidance of
rehospitalization as one of the indicators, and track the patients, the difference between hospital-based and freestanding, is there a difference in the frequency of rehospitalization between the two? I assume there is a difference in terms of staffing. I thought that's what I understood you to stay in the text and you just comment on different models. I assume one of them is the use of RNs versus non-RNs and the presence and whether or not that has a direct impact all of the other issues that patients confront in terms of lengths of stay, rehospitalization. Are there qualitative differences in what's occurring between the two settings? And are we able to track that?

MS. LINEHAN: We're continuing the work that we started with the University of Colorado where they developed these measures and looked at the national rates. One of the things we're looking at is differences by facility type in not only the level but the rates of change over time. We haven't presented any of that work yet. They're still working on some of the differences in the facility rates.

MS. BURKE: I think you're right, our goal is not
to differentiate payment based on the where, but rather on
the kind of service. So you don't want to just uniformly
say hospital-based units ought to get a different update.

But if, in fact, we're able to determine whether
there is a qualitative difference between the two, the
shorter lengths of stay are, in and of themselves, not a bad
thing. There are questions in terms of the management of
very acutely ill post-hospitalization patients, whether
they're ventilator dependent, whether or not they're on IV
antibiotics. And there is difficulty in placing them in
freestanding facilities, although they are spread clearly
across a variety of facilities.

But I think it would be very important for us to
understand the extent to which those things translate into
quality issues, whether there is, in fact, a difference
between these different kinds of facilities. Because the
extent to which they continue to have hugely negative
margins, and whether we are discouraging the presence of
those kinds of facilities, or whether the hospital is just --
-- we presume they can just suck it up over a period of time
and keep them going regardless.

But I think we need to understand whether there
are real qualitative differences in staffing and all the indicators between the kinds of patients have are being and how.

MS. LINEHAN: We're going to have results but we don't have them yet. We're going to have them in the spring. We are looking at staffing. We know there is a difference in staffing, just if you look at the OSCAR data. But how does that relate to differences in quality and costs, and try to sort out at the facility level what the relationship is between staffing, quality, cost and other facility characteristics.

MS. BURKE: And severity, some kind of adjustment to track the patient may be the way to solve that problem as compared to entirely separate rates. But I think that will be important to know.

DR. KANE: Another clarification issue.

I thought when we talked about the hospital updates that the hospital-based SNF was folded in and was part of the reason we -- now I'm confused because when we looked at the hospital-based, the margin included the SNF and the HHO. But we're saying this doesn't affect the SNF at all. So this is for hospital-based and freestanding,
this recommendation?

DR. MILLER: The update would be the impact of the margin as reflected in the hospital setting because for a whole variety of reasons, including the problem with cost allocation. But the update that we ultimately make here will have an affect on both freestanding and hospital-based.

MR. HACKBARTH: A reason for that, as Sheila indicated, is going down that path of having different payment rates based simply on a provider type is a problematic path. In fact, in a lot of ways that's where we're trying to get away from, our issues around long-term care hospitals.

The question is can those same patients be treated in the facility with a different name over the door and achieve quality care at a much lower cost? And so we don't want to just be paying more because it has a certain provider type.

DR. KANE: I'm all for one payment regardless of site, the same thing. I guess the issue is whether there's some sort of synergy that only the hospital can obtain. Which is what I thought you were saying there might be.

In which case, would we be adjusting payment or
not? Because if that same type of patient was treated in a freestanding, they would not be able to achieve the same type of synergy as if they were in a hospital-based SNF.

MS. BURKE: I don't think it's a synergy issue.

DR. KANE: It is in if the hospital gets the benefit of getting the patient out faster, then there is a little bit of a synergy if --

MR. HACKBARTH: If they can't do the same thing with a freestanding SNF.

DR. KANE: That's what I meant.

MR. HACKBARTH: To me the significance of what Kathryn presented was she gave a series of potentially rational reasonable explanations why hospitals might persist in this business despite the reported negative margins of minus 89 percent. One is, as Ralph has said in the past, some of these patients are just very difficult to place in freestanding SNFs, in some cases maybe because of flaws that we've often noted in the case-mix adjustment for freestanding SNFs. So that's one rational reason.

Another is that hospitals look at them as a joint activity. And when you combine both the SNF payment and the inpatient payment, that it's a reasonable financial thing to
DR. KANE: It works better than if you didn't have it because you'd be stuck with the patient on a DRG --

MR. HACKBARTH: They may feel marginally more comfortable moving the patient out of the acute hospital into the SNF if a SNF is on-site with their staff. And they might be a little more reluctant to a free-standing facility.

DR. WOLTER: I would like to underscore Sheila's comments. I think we're doing good work in this area now. Certainly in our facility the patients going to our hospital-based SNF are more on the cusp between acute care and post-acute care than those that go out into the freestanding SNFs.

When we did the LTCH visits a couple of years ago, we heard loud and clear in a couple of the communities that there really weren't any freestanding SNFs that could take some of the patients they were taking care of.

So I think there's some differences here. I think the points made in the chapter, that these are often patients where there's a high probability that a relatively short length of stay will get them home, differentiates them
a bit from those who go out to the freestanding SNFs. So I think the work you're talking about
continuing on will be very useful because if there is value in the hospital-based SNFs -- and a third of them have
exited, if I'm remembering the numbers we've looked at previously -- zero percent updates over a number of years
could have a valuable resource be affected.

We didn't look at it the way you described it but I think it's very similar. Every time we've analyzed the
financial impact of eliminating our hospital-based SNF, it's kind of a wash, I would say. Even though we're losing money
over there, there are some benefits on the inpatient side and there's clearly been clinical benefits to the patient.

So it seems to me we're starting to get our arms around this and that's good to see.

MR. HACKBARTH: Other questions or comments? Why don't you put up the recommendation.

All opposed to the recommendation? All in favor? Abstentions?

Okay, thank you. Next up is home health.

MR. CHRISTMAN: Good afternoon. Next I'm going to take you through the home health benefit and review some of
the things I shared with you at the last meeting.

MR. HACKBARTH: Even, before you start, it just occurred to me that I forgot to mention on Karen Borman's behalf that she supported the recommendation of no update for SNFs.

MR. CHRISTMAN: Up here on the screen you'll see a lot of the information I presented at the December meeting for home health.

We found that access to care is generally pretty good, 99 percent of beneficiaries live in an area served by home health. The volume of services for home health continues to grow. The number of episodes increased by 9 percent and the number of users increased by 6 percent. Total home health spending will reach about $11 billion in 2005.

In terms of quality measures, you remember I showed you six of them. The first four were functional measures and those were generally increasing over time. The exception to that were the two adverse event measures where we had seen level or no change in the number of rehospitalizations or ER visits in the last four years.

Finally, you might remember I mentioned that the
The supply of agencies continues to increase. We expect an increase of about 6.3 percent in 2006, an increase of over 500 agencies.

As I commented last time, the variation in growth among the states is insignificant. This next slide kind of walks through some of that.

Before I go through it, I want to lay out a couple of caveats to the data I used to put this table together. These numbers are based on the net change in the number of providers in a state over the four-year period. That is it accounts for the churn that can occur as new providers enter and other providers exit.

Also, since home health is not facility-based, the site of care isn't at least at a facility, the change in the number of providers in an area does not necessarily measure the change in the capacity to deliver care. Agencies can adjust their service areas as local conditions change.

Some of the change we see may be due to consolidation such as mergers. Again, this would reduce the number of individual providers but again, it doesn't necessarily affect the capacity in the local area.

With this point in mind, let's go through the
table. The first row shows that 18 states experienced an
decreased relative to where they were in 2002 by 2006. The
average change for that category was about five agencies.

However, in these category and in each of these
categories, among those 18 states, there was a broad
variation in the size and the number of providers. So the
absolute change can be misleading.

Just as an example, Montana had 50 providers in
2002 and it fell to 37 by 2006 or lost about a quarter of
them. For other states who were much larger the average
change was still pretty small but the decrease as a
percentage was much smaller, frequently in the low single
digits.

The next row down is just the no change. There's
not much to say about that. Those are states that didn't
change over the four-year period.

The line below that shows that 25 states
experienced moderate growth of between one to 31 agencies.
The average state in that category grew by about nine
agencies.

The final row shows where most of the growth has
occurred. It shows that six states increased by 90 agencies
or more and by an average of more than 270 agencies.

MR. BERTKO: Evan, just out of curiosity, do the

53 total mean you have the two territories there?

MR. CHRISTMAN: We have Puerto Rico and the Virgin

islands in this.

DR. REISCHAUER: I thought it was Northern and

Southern California.

MR. CHRISTMAN: The last category, the six states

are Florida, Texas, California, Illinois, Michigan and Ohio.

I would note that four of those states, Florida, Texas,

California and Illinois, were targeted for additional

enforcement activities as a part of Operation Restore Trust

in the home health area.

We recognize that these numbers show a tremendous

growth in certain areas of the country and we've discussed

this with CMS. The numbers that we show here match their

expectations.

At the last meeting there was a question about the

relationship of Medicaid and the growth we're observing,

specifically whether the trend in Medicaid towards moving

people out of institutions and into the community was

affecting some of this growth. We did some further research
and spoke with the industry on this issue and we really couldn't find any clear linkage between Medicaid and the growth.

Again, as you're probably all well aware, the Medicaid programs vary tremendously across the country, as do market conditions. For these reasons, it's difficult for us to assess how the shift to community-based services has affected growth.

This next table we saw at the last meeting. It shows what the home health agencies' margins were in 2005. I'll just go through quickly. Overall, we found that their margins were 16.7 percent. It's worth noting that there is some variation, that the agency at the 25th percentile of the margin distribution had margins of 2.3 percent. The agency at the 75th had a margin of 27.2 percent.

Looking below at geography the story is very similar to what we found in previous years. The agencies that serve beneficiaries in both rural and urban areas had the highest margins. They're referred to as mixed. You'll see them there, they're 17.7 percent. And then the rurals had the lowest margins. Still their margins were 13.7 percent.
Under type of control, you'll see again that the for-profits continue to have the highest margins of about 18.2 percent and the government agencies continue to have the lowest margins, still over 10 percent.

In terms of costs per episode, our findings were similar with what we found in previous years. Home health agencies continue to have a lot of success controlling costs. Our findings show that their costs per episode only grew by 0.7 in 2005. This is below the market basket inflation for that year, which was 3.1 percent. Again, this is a trend we've seen in past years where the actual cost growth we observe is less than 1 percent and the market basket increase is generally between 3 and 3.5 percent a year.

This shows that agencies continue to effectively control their costs and keep their annual inflation well below that you'll find in the market basket.

Really quickly, I'm going to walk through the payment changes for 2006 and 2007. Home health agencies were held at the 2005 levels for 2006. That is they didn't get a market basket update. The one exception is for beneficiaries in rural areas there was a 5 percent add-on
that was only in effect for 2006. It was not extended in
the most recent bill.

There's also a new pay for reporting requirement
that goes into effect in 2007. For this year home health
agencies will receive the full market basket of 3.3 percent.

Based on this information, we estimated the margin
for freestanding agencies will be 16.8 percent in 2007.

That takes us to our recommendation. Our
recommendation is the Congress should eliminate the update
to payments for home health care services for calendar year
2008.

Home health agencies will receive a full market
basket of 2.9 percent in 2008 under current law. They
continued trend of low cost growth and high margins indicate
that agencies should be able to observe any cost increases
within existing payments and that the market basket increase
is not necessary.

This would decrease spending relative to current
law by $250 million to $750 million in 2008 and between $1
million and $5 billion over five years.

We believe this would have no effect on providers'
ability to furnish care to Medicare beneficiaries.
That completes my presentation.

MR. HACKBARTH: Comments?

DR. REISCHAUER: About every couple of years I bring up this point, Evan, and it's not solely with respect to home health. It's several of the other provider groups, too.

We're stuck on providing unbelievable detail on institutions which are a rather meaningless concept, especially here but I think it's also true in hospitals, where we don't talk about bed-weighted hospitals or anything like that. We're counting a little gut and a huge guy as if they were the same.

And here we aren't even sure when an agency means. We go through the number of agencies and we take comfort in the fact that they are growing like bandits in most of the country.

And really what you care about is percent of Medicare beneficiaries who have access to this type of care -- and you said it was 99 percent -- and tracking that.

And then the change in episodes per 1,000 beneficiaries and whether one agency provides that or 500 doesn't really make that much difference for the kinds of
things that we're concerned about. Maybe you want to get
into the change in the growth of episodes by the level of
episodes per 1,000 beneficiaries that are available to see
if these things are growing fastest in the areas where there
is the most being provided or the least being provided.

But I think in the future we should -- you know,
the only place we really do this is in dialysis centers
where we talk about the number of stations and the
difference between the chain-related ones and non-chain-
related ones.

But I don't know what kind of comfort I should get
from all of the numbers that we provide, or discomfort, for
that matter. I think we can simplify a lot of this and have
it more meaningful.

This is a criticism of how we've been doing this
for 10 years really and a suggestion for the future.

MR. HACKBARTH: I agree with your point, Bob, that
home health is particularly difficult and that the concept
of an agency is elastic, shall we say, and it ranges from
Carol Raphael's VNA in New York to the mom and pop home
health agency run out of the gas station. The agency
numbers, I think, are particularly problematic.
But just to be clear -- and I know you know this -- the margins for this and all of the sectors are patient weighted. They're not facility weighted or agency weighted. The reflect the volume of patients.

DR. MILLER: So given that, if I could just get you to say a little bit more. I think in last month's presentation we did go through things like growth in the number of episodes and that type of thing, if I recall.

MR. CHRISTMAN: We did do that.

DR. MILLER: And then we went through the access information to the extent that we have it. Maybe if you could just kind of hit again what's the innovation you're looking for.

DR. REISCHAUER: I think that's great. But then the document we're going to publish for the public has none of it in it. Is that not this or not?

MR. CHRISTMAN: That's in there. There should be a table in there that shows the episode volume and the user volume, for example, that we've seen over the last five years.

DR. REISCHAUER: You're talking about states and things like that. That's what I'm talking about.
DR. MILLER: The state analysis, if that's what you're referring to, that was an innovation because of the question asked the last time. And that will be -- we can put that in the report. It maybe hasn't made its way into it as of yet.

MR. CHRISTMAN: Not in the way you saw it here.

DR. MILLER: That can certainly get in there.

DR. REISCHAUER: We have a client that is geographically based, shall I say, and is going to focus on the fact that five states have declines or eight states or whatever it is, and get all hot under the collar about that.

DR. MILLER: I see, and you want to make it more clear in the future.

DR. REISCHAUER: I don't know if there is a problem but I suspect there isn't a problem in that respect, and that there's been growth in episodes per 10,000 beneficiaries, that's been robust even in those areas.

DR. MILLER: That's I was looking for. Thanks.

DR. REISCHAUER: Do I care that there's been umpteen million new agencies set up in Florida or California? I would expect so. I don't expect it to happen
in North Dakota. It has to be relative to the potential demand.

DR. SCANLON: I was going to agree with you, Bob, except for that last comment. I maybe care about California and Florida.

I think when we go back to the Operation Restore Trust era, even though the concept of an agency in terms of a supply indicator is weak, the gross differences across states, we did see problems between the areas where there was huge numbers of agencies. Texas had 2,000 at its heyday.

And we saw that in areas where there were controls over the supply of agencies, like Vermont where it didn't change because there's one per county and you had rules like that. There were huge differences in terms of the provision of services that in the states where there was this large proliferation of agencies, we saw tremendous growth in visits per beneficiaries. And in other places we saw none in the same time period under the same payment system.

So I think it is useful to bring more of the state work into our publication, as well as to group the states in terms of where is the growth happening? And are we starting
to see some of the same problems?

We have a fairly poorly designed episode here in terms of what is required and the margins and the distribution of margins reflect that. And so knowing more about what we're getting and how we should be intervening in terms of greater oversight is very important.

DR. REISCHAUER: But you really should agree with me because I'm saying we should do episodes per 1,000 beneficiaries, not number of agencies.

DR. SCANLON: We were disagreeing on whether I want to look at California or Florida.

DR. REISCHAUER: I want to look at them but using the right metric.

DR. KANE: I'm just concerned when the episode growth is only 0.7 of a percent that there isn't something fatally flawed about the episode definition.

MR. HACKBARTH: The cost per episode?

DR. KANE: The cost growth is only 0.7 of a percent. What's changing it? I'm guessing it's that there's fewer units of service being provided per episode. And I'm also guessing perhaps there's classification issues that are really not right on target and that there is
capability to get the less sick people into the higher cost
episode, the higher paying episode. And that's what this
signals to me is that there's something fundamentally with
the episode system.

I remember last year, in my fog of the first year,
we did something about cost and case-mix not explaining
something about episodes. But it seems we need to do
something a little more. Because 0.7 of a percent, even
with minimum-wage workers there's something wrong with --
fuel costs? Something's got to go up.

MR. HACKBARTH: We have several times over the
last several years expressed concern about the case-mix
system and whether, in fact, it appropriately adjusts for
the expected costs of different types of patients. That's
been one set of issues that we've raised repeatedly.

A broader concern, that Bill has often mentioned,
is that in home health, probably more than any other sector,
the definition of what it is we are buying is obscure. That
could be affecting the cost growth.

Some of the things that account for low cost
growth are relatively straightforward. In some parts of the
country there were a lot of visits per episode and those
numbers have been coming down. The average has been coming
down. Although that decline has slowed in recent years.
But for a while that provided sort of one ready explanation
of why costs per episode growth would be low.

DR. KANE: If this were physician RVUs, we would
say we should be recalibrating these or reweighting these.
In other words, is there something that needs to be
rewighted now that visits per episode have come down?

MR. HACKBARTH: Another potential factor is
substitution of lower wage staff for higher wages staff with
uncertain implications for quality. We've tried to look at
available measures of quality for home health but they are
relatively few in number, although the ones we have suggest
stability or even slight improvement on average.

This is a very difficult area to get a grip on.
And when I look at those high average margins, as opposed to
looking at them and saying oh everything is okay in home
health, I think the spin is a little bit different. I think
the spin is money is not the immediate pressing problem.
But there may be a host of other problems in the home health
payment system around how the dollars are allocated.

Evan, can you tell us where the work stands on
refining the case-mix system for home health? Is any
progress being made on that?

MR. CHRISTMAN: CMS has an effort underway to
develop a refinement rule and our understanding is they're
supposed to come out with a rule soon. But when that is
this year it's not clear, but they do have an effort
underway to look at refinement issues.

DR. MILLER: Just to say something more broadly,
this same issue has been kind of enjoined on the SNF side at
different points in time. So we've been working in the
background, in the midst of everything else, and we're
hoping to bring online -- I think this spring, which is in
just a couple of months, March to be exact -- a discussion
of what those ideas are.

And then we were sort of looking ahead to CMS to
maybe kick that process off for home health and then maybe
use that as a springboard to start that destruction.

If, like SNF, that doesn't quite happen, then
we'll move ahead and start to develop our own sets of ideas
and bring those in front of you.

But in terms of the priorities, we've kind of been
drilling down on SNF. That come up literally starting in
March and then we'll see what happens with home health and
start drilling there.

DR. SCANLON: I'm not sure if I heard this but they're two different refinements. There's one, the issue
of refining the patient classifications. And then there's,
secondly, refining the episode definitions or the episode
structure. And we, I think two years ago, had a discussion
about that briefly, but I think we need to revisit that.

DR. MILLER: We would look at all of it. We wouldn't just say we'll stick with the 60 days and get to
the patient classifications. I think we would open the
whole thing up.

MS. BEHROOZI: Actually, Nancy foreshadowed a little bit of what I was interested in, and you did also,
Glenn.

I think home health is unique in relying significantly on the labor of low wage workers to provide
the service that Medicare is paying for. I mean, there are obviously significant other components to it, in terms of
therapy and registered nurse services and things like that.
But in all the different areas, this is the one that really a chunk of the payment goes to pay for the services provided
by low-wage workers.

It's been a number of years, hopefully it's over now, that the federal minimum wages hasn't gone up. I wonder whether you see differences in margins between the states where minimum wages are higher and puts a little bit upward pressure on the wages of low wage workers?

But our experience in providing health care or trying to provide health care for these low-wage workers, is that the employers are part of that 20 percent that actually didn't show up in the chart, I guess they're below that 25th percentile, who have negative margins. So the distribution of margins is pretty broad. It's almost a 30 point spread. And you say it's been consistent over a few years.

So I guess some of those employers that have been experiencing the consistently low margins who, if our recommendation is accepted, won't be getting an update again, will go back to their workers and say sorry, I can't give you any more money. Because that's the only place where they can achieve the efficiencies -- not the only place. But given that it's such a big chunk of the cost, that's a place where they're going to have to look to make those efficiencies. So they won't "be able" to raise the
workers wages or benefit levels.

And those that have the same high margins that they have had for several years, I guess that's where they look, that's one of the only places -- not the only place, but that's one of the major places they look to protect their margins because there isn't any other pressure requiring them to pass any more of that money that Medicare pays onto the workers who provide that direct service.

So I feel kind of caught in a quandary here, looking at the aggregate margins. It certainly doesn't look like you need to put any more money into this sector, they're doing fine. But thinking that I understand, at least from our local corner of the world, a little bit about how those vary widely distributed margins have stayed the same over the years on the backs of these low-wage workers, I don't feel good about saying no, we shouldn't increase the rates because that's what the agencies will say to their workers.

I'll save for tomorrow, I guess, when we talk about home health quality pay for performance measures, talking about some of the ways in which we might look at some factors other than outcomes measures but structural or
process measures about worker training or incentives
designed to enhance worker retention which I think is an
area that we need to look at in terms of its relationship to
quality.

MR. HACKBARTH: Evan, could you put up the table
that has the margin information on the distribution?

I understand what you're saying. What this says
to me, though, is that even at the 25th percentile we've got
an average margin of 2.3 percent. Let's stipulate that with
the people that you're talking to there are some issues
about the ability to hire workers.

What this says to me, though, is that if you add
more money to the system it's not going to be spent on
higher wages for low-wage workers.

MS. BEHROOZI: I understand that, Glenn. As I
said, I don't advocate putting more money into the system
because they're protecting their margins. I think that's
really the message. Though there are 20 percent of them --
as I said it doesn't show up on the chart, it's in the paper
-- there are 20 percent of them that are at negative
margins. So they have a little better case when they plead
poverty, perhaps.
But no, I completely agree with you, it's clear that there has been no shift. They've been taking advantage of the fact that there has been no upward pressure on the lowest wages and keeping the margins that healthy looking. I agree.

DR. REISCHAUER: Evan, do you have any idea what impact the rise in the minimum wage might have on the cost of this sector?

MR. CHRISTMAN: Obviously, for those workers affected by it, it would raise their wages. We didn't do anything like that in our modeling.

Our experience has been, though, that across the years, whatever changes have occurred across the last five years, these providers have been successful at keeping their cost growth very low. So if they're faced with an increase in wages, the track record suggests that they will have an ability to adjust to it.

DR. REISCHAUER: But as Nancy pointed out, we don't know if this ability is the revelation of productivity or stinting on care that we can't pick up because our quality of care measures are too crude.

MS. BEHROOZI: It's more than five years since the
federal minimum wage went up.

MR. HACKBARTH: Other questions or comments on home health?

Would you put up the recommendation?

Okay, all opposed to the recommendation? All in favor? Abstentions?

Okay, thank you. Evan.

Next is inpatient rehab facility hospitals.

DR. KAPLAN: Inpatient rehabilitation facilities, or IRFs, make up the third post-acute care sector we'll access for payment adequacy today. I'll review the evidence on the factors I presented last month and these will hopefully inform your discussion of the recommendation.

The number of IRFs increased slightly after the PPS started in 2004 at 1 percent per year, but between 2004 and 2005 stayed the same. Rural IRFs, however, have grown rapidly at almost 7 percent between 2004 and 2005. This growth is consistent with a 21 percent payment adjustment for rural IRFs under the PPS and critical access hospitals' ability to have IRF units starting in October 2004.

Between 2002 and 2004 the volume of cases and Medicare spending increased rapidly while average length of
stay decreased. Spending increased 16 percent per year during this period.

In 2005 the story changed. There was a drop in the number of cases and a shift in the type of patient who was admitted to the IRF due to the modification and enforcement of the 75 percent rule.

Between 2004 and 2005 the volume of cases dropped 10 percent and spending dropped 3 percent. The drop in volume resulted in more complex patients continuing being admitted to IRFs while less complex patients went to alternative settings.

We have no direct measures of access and the decrease in IRF cases is difficult to interpret. The number of beneficiaries who used IRFs, in indirect measure of access, increased 3 percent between 2002 and 2005. In some markets IRFs closed and in other markets that previously had none, IRFs opened.

To assess quality we examined the difference in functioning at admission and discharge and found that all patients using IRFs and those discharged home improved functioning slightly from 2004 to 2006.

More than 80 percent of IRFs are hospital-based
and access capital through their parent institutions who have good access. In addition, private equity firms are investing in freestanding IRFs. These facts suggest IRFs have access to capital.

Now we look at the comparison of payments and costs. As you can see from the chart on the screen, under TEFRA -- which is pre-PPS -- the change in costs per case were slightly greater than the change in payments per case. Under PPS, payments per case increased rapidly. Costs started to accelerate in 2004. In 2005 the 75 percent went into effect and costs per case accelerated rapidly, increasing by 10 percent as volume of cases decreased and CMI increased. This is what we know up to 2005. Of course, this is the last cost report information we have. But we do think IRFs are trying to control costs.

Last month commissioners questioned what IRFs are doing to control their costs as volume drops. We went back to the industry, as you suggested, and they told us they are closing beds and reducing staff. The industry also raised concerns about enforcement of the 75 percent rule. The industry reported that some FIs are being very aggressive in
denying claims. We've been unable to confirm this information with CMS.

In 2005, the aggregate Medicare margin for IRFs was 25 percent. IRFs at the 25th percentile had a margin of negative 4 percent. IRFs at the 75th percentile had 22 percent. As you can see, there is a similar pattern between hospital-based versus freestanding IRFs and nonprofit versus for-profit IRFs. Hospital-based IRFs are predominately nonprofit, as hospitals are, while freestanding IRFs are predominantly for-profit.

Government IRFs have a 5 percent margin in 2005, although these IRFs have few Medicare cases and don't operate under the same constraints as other facilities.

We estimated a margin of 13 percent in 2005 and a margin of 2.7 percent in 2007. The 75 percent rule has the biggest effect on the projected margins. To model the 2007 margin, we had to make several assumptions. In part, we based these assumptions on what IRFs experienced in the first year of the phase-in of the 75 percent rule.

20 percent of the IRF cases disappear between 2005 and 2007. We tried to be reasonable in making assumptions about costs. We assumed that IRFs are able to get rid of 90
percent of the direct costs or patient care costs for the patients they no longer admit. We assumed that indirect costs don't change. These assumptions together bring us to the 2.7 percent. If we vary those assumptions, the margin would be between 0.5 percent and 5.5 percent.

To recap the payment adequacy factors: supply, quality, and access to capital are positive. Volume is down and access is difficult to interpret. We project a significant drop in margins. The range in margins depends on what one assumes about costs.

On the one hand, IRFs have enjoyed strong positive margins for several years. On the other hand, there has not been the rapid growth we've seen in other post-acute sectors. We've observed the effect of the 75 percent rule on the number of cases and the types of cases admitted to IRFs.

In December we discussed a zero update for IRFs. The alternative I'm presenting is a 1 percent update. The draft recommendation is on the screen. The Congress should update payment rates for inpatient rehabilitation facility services by 1 percent for fiscal year 2008.
The update in law is market basket. Implications of the recommendation are that it decreases federal program spending relative to current law by between $50 million and $250 million in one year and less than $1 billion over five years.

For beneficiaries and providers, we expect no effect on providers' ability to provide care to Medicare beneficiaries.

That concludes my presentation.

MR. HACKBARTH: Questions or comments? No one?

MS. DePARLE: Where did you come up with 1 percent? It's not market basket minus productivity.

MR. HACKBARTH: From moi. It would be wrong to suggest some way of calculating 1 percent.

The factors that seems significant to me, and Sally touched on all of them, that this is an industry that has had high margins for a number of years in the past. We are in the process of seeing a significant change and reduction in those margins, largely attributable to the 75 percent rule. So I think a case can be made for something higher than the zero update that we've recommended in the past.
But in view of where they've been in the recent past, with I think double-digit margins each of the last three or four or five years, I don't think that market basket minus productivity -- which is sort of our starting point, our benchmark, would be appropriate. Hence, something between market basket minus productivity and zero, and that's around 1 percent. That was my logic.

DR. MILLER: This is, I think, just a minor clarification but Sally, it's more like two or three years they've had those higher margins?

DR. KAPLAN: You're right. They went into the PPS in 2002 and so 2003, 2004 and then 2005 is above 10 percent. The first year was not, but ramping up.

MR. HACKBARTH: The projected market basket is what?

DR. KAPLAN: 3.1 percent, like all the other post-acute.

MR. HACKBARTH: So 3.1 percent minus 1.3 percent, which is the productivity adjustment, would be 1.8. this is sort of between the zero and that.

It's science.
MS. DePARLE: No, it's a policy judgment, and that would be my point.

MR. HACKBARTH: Other questions, comments?

DR. KANE: You do get concerned about how well the case has been adjusted, given the profit margins. But do we have a sense that once the 75 percent rule is in place that the payments and costs are pretty much calibrated to each other?

Unlike home health, where it looks like things are pretty far out of whack, do we have a sense that once the 75 percent rule is in place that this big spread in your third slide here will really go away? You know there's a huge ramp up in costs over the period.

DR. KAPLAN: Let me speak to that. The IRF PPS is a good prospective payment system, and so far the payments have been -- for the individual case-mix groups -- have been very closely calibrated to the costs. It was recently revised. In fact, I believe for fiscal year 2006. And the weights are recalibrated every year which is in contrast to what you see with the SNFs and home health.

As far as to whether the difference in the margins will go away, I'm unable to predict that.
DR. MILLER: Another part of that answer might have been is we're still -- and this in part this is reflected in our estimated margins -- we're still trying to watch how the industry is going to respond to these changes. I think that also drives some of the policy judgment here, is that you have this impact occurring from these rules. Things are happening. Admissions are dropping. Exactly how they're going to calibrate out the admissions and respond with their cost structure to a different presumably type of patient, because the 75 percent rule went after a type of patient, is I think also a little bit in flux right at the moment, which might make it hard to answer that question.

DR. REISCHAUER: Just a question. 81 percent of these institutions are hospital-based and presumably all the problems that we have with SNFs and hospital-based SNFs apply as well? Or not?

DR. KAPLAN: Craig did a pretty careful analysis last year on the comparison of hospital-based versus freestanding. He should speak to that. Is that going to answer question?

DR. REISCHAUER: I don't know. I'm all ears.

DR. KAPLAN: Are you asking about cost allocation?
MR. LISK: If you go to the TEFRA period before we went to the PPS, we actually saw margins about the same for freestanding and hospital-based IRFs.

The other thing that's of interest here is for the freestanding IRFs, IRF business in Medicare is their primary line of business. On the freestanding SNFs, Medicare is not their primary line of business. So there could be cost allocations issues on the Medicare side in the freestanding SNFs that produce some of the disparities. But what we saw were very similar margins.

We've seen more disparity once the PPS went into effect in margins with the hospital-based margins being a little bit lower than the freestanding margins.

But the interest is in the TEFRA period we saw the margins for both freestanding and hospital-based about very similar to one another.

DR. MILLER: This question came up a year or a year-and-a-half ago or however long ago it was and we went through fairly extensive analysis and talked it through a lot of hospital people like Nick and Ralph and some others and sort of had this conversation and came to a consensus that we thought we could move ahead with these.
MR. HACKBARTH: Others? Okay let's proceed to a vote.

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

Okay, thank you.

DR. KAPLAN: It's us again. Last but not least are long-term care hospitals.

The last post-acute care payment adequacy assessment is for long-term care hospitals.

As with IRFs, I'm going to review the evidence we presented last month and then after give you the draft recommendation and its implications, I'll tell you a little bit about the RTI study of the feasibility of CMS's adopting our recommendations to establish criteria to define long-term care hospitals. This study is hot off the press. It was published on December 26th and is in your tab A of your folder.

Under the PPS, supply of long-term care hospitals grew 10 percent per year. The same number of long-term care hospitals entered the Medicare program in 2005 as in 2004. Hospitals within hospitals entered at a faster pace than freestanding long-term care hospitals. Many of the new
long-term care hospitals have located in markets that already have long-term care hospitals, which raises questions about their role, especially because the patients who need this type of care are relatively rare.

Under the PPS, the number of long-term care hospitals also increased 10 percent. Spending increased almost triple that rate at 29 percent per year.

Although we have no direct measures of access and can't tell which beneficiaries actually need this type of care, the number of beneficiaries who used long-term care hospitals increased 10 percent per year under PPS.

As far as quality is concerned, we examined four different types of risk-adjusted quality measures and found mixed results. On the positive side, the rate of death in the long-term care hospitals and the rate of death within 30 days of discharge and one patient safety indicator improved from 2004 to 2005. On the negative side, readmissions to the acute care hospital and three out of four patient safety indicators worsened between 2004 and 2005.

Long-term care hospitals have adequate access to capital. Private equity firms have invested over $3 billion in this industry between 2004 and 2006.
This chart shows how changes in payments per case have compared to changes in costs per case. Under TEFRA changes in costs were slightly higher than changes in payment per case for most years before the PPS began. Payments have increasingly under PPS. And as payments went up, so have costs. The increase in payments has been driven by observed case-mix. However, almost two-thirds of the case-mix increase has been coding improvement.

The 2005 Medicare margins are on the screen. In 2005 all types of long-term care hospitals except government-owned facilities had positive margins. Government long-term care hospitals are few in number. They have few Medicare patients and they operate under constraints than other long-term care hospitals.

For purposes of projecting the 2007 margins with 2008 policy, we modeled the changes on the screen. As you can see, there were a number of policies to include in the model. The changes for 2007 are the reason for the drop in margins from 2005 to 2007. Effectively, CMS froze payments for 2007. In addition, they changed payments for short stay outliers and that reduced payments as well.

The range of zero to 2 percent in 2007 results
from uncertainty about how hospitals within hospitals will behave in response to the 25 percent rule.

Just to remind you about the 25 percent rule, growth in hospitals within hospitals resulted in CMS establishing a new policy to ensure that hospitals within hospitals don't act like hospital-based units. The 25 percent rule reduces payments when hospitals within hospitals admit more than 25 percent of patients from their host hospitals. There are some exceptions to the rule and these have a 50 percent threshold.

As we mentioned last month, CMS may not have the tools to enforce this policy at this time, especially since there is no systematic way to identify hospitals within hospitals or their host hospitals. There are also a lot of possible ways to respond to the rule. For example, hospitals within hospitals can take a larger share of outliers from the host hospital, who are not subject to the rule. They could make arrangements to take a greater share of patients from hospitals other than the host hospital, including trading patients. Hospitals within hospitals can become freestanding long-term care hospitals or there can be other arrangements that can make hospitals within hospitals
willing to take a financial hit on patients over 25 percent. I want to recap the evidence. All but one factor we use to assess payment adequacy are positive and suggest generous payments. From 2002 to 2004 we have seen high margins across the whole industry. Margins are projected to fall because of CMS's aggressive action.

Commissioners might want to consider that even with those changes rapid growth in Medicare spending continues. We found spending for long-term care hospitals was $4.5 billion for 2005. CMS projects that Medicare spending for long-term care hospitals will be $5.3 billion in 2007.

Commissioners also might want to note that the reaction of hospitals within hospitals to the 25 percent rule is uncertain. Hospitals within hospitals make up the majority of the long-term care hospital industry. There are no criteria to define these facilities and patients yet. It is possible that keeping the pressure on with the zero update will be more likely to bring the industry to the table about criteria.

The recommendation is on the screen. The Secretary should eliminate the update to payment rates for
long-term care hospital services for rate year 2008.

Implications of this recommendation are that it decreases federal program spending relative to current law by between $50 million and $250 million in one year and less than $1 billion over five years.

For beneficiaries and providers, we expect no effect on providers' ability to provide care to Medicare beneficiaries.

Before you discuss the draft recommendation, I'd like to give you some information on the RTI study. As I said, we've included it in tab A of your mailing materials and a summary of the study is included in a text box in the draft chapter.

CMS contract with RTI to study the feasibility of adopting MedPAC's recommendations to better define long-term care hospitals by facility and patient criteria. The RTI study has a number of major findings. Many are similar to the findings from our study of long-term care hospitals, although the timing is different. Our study was before the PPS began. RTI's study was after the PPS began.

The results of the study led RTI to recommend ways to better define long-term care hospitals that are similar
to our recommendations. MedPAC and RTI differ in how they
suggest defining medically complex patients. We suggested
that long-term care hospitals have a high percentage of
patients who demonstrate a high level of severity, for
example 85 percent. RTI's recommendation goes further and
recommends that CMS develop a list of criteria to measure
medical severity for long-term care hospital admissions. To
develop this list, CMS would establish a technical expert
panel who would develop a set of criteria and recommend how
to measure them.

We believe that all of these recommendations are
similar to the Commission's recommendation for admission
criteria that includes patient-specific clinical
characteristics and need for specific treatments and it
ecompasses our suggestion for a standard patient assessment
instrument.

RTI also recommends measures that would make long-
term care hospitals more similar to acute care hospitals and
that CMS take administrative action to better identify
hospitals within hospitals.

As I said earlier, the RTI report just came out
December 26th. There's no way to tell whether CMS is going
to implement any or all of the recommendations in the proposed rule that is due out this month.

That completes my presentation.

MR. HACKBARTH: Questions or comments?

DR. WOLTER: Having been part of the site visits, it's really nice to see how the follow-up work is going. And it seems like this is very, very solid work so I congratulate you on that.

I did see one comment I thought was a little bit harsh in the text, and that is on page 15 under the rationale, the Commission concluded that a very limited number of patients are appropriately treated in these facilities.

I say that because when we did our site visits, especially the best facilities, it became very clear to me that there is a subset of chronically, critically ill patients who in the right setting probably are getting better care than they would in most acute care hospitals or in any other long-term care setting.

So I think the appropriate wording is elsewhere in the text, which is it's unclear what criteria we should use to make sure the right patients are going into these
facilities and hopefully our recommendations and the RTI
recommendations are going to get us on the right path.

At least that's the context I remember, Sally, but
you might want to comment.

DR. MILLER: The only thing I'll comment is -- and
I agree, we'll change the sentence. You're right, we didn't
necessarily conclude that there was a limited patient
population.

But I think what we were reaching for when we
wrote that is that we found that when you narrowed it and
focused it on the most severely ill patients is when this
benefit looked like it was a cost-effective choice for
Medicare. We'll just make sure that that point gets clear.

Your point is taken, though, that the criteria
needs to be established to determine exactly who is coming
in these doors.

MS. DePARLE: I agree with Nick and I have a
couple of other questions.

First, Sally, on the margins, on slide five, you
talked about the estimated margin for 2007 and that there
was a swing of zero to 2 percent. I'm not sure I followed
how you got there. I got the impression it depends heavily
on how the hospital within hospital 25 percent rule is
enforced. So can you give me a little more detail around
zero to 2 percent?

DR. KAPLAN: The range is dependent on how
hospitals within hospitals respond to the rule. If they
make no changes in their behavior whatsoever, then we would
expect it's basically 0.1 percent. If they completely
change their behavior or they find ways to get around the
rule, then it would be 1.9 percent, which we basically
rounded up to 2 percent.

And as we said, there's a lot of uncertainty about
this rule and also CMS's ability to enforce it since they
can't identify hospitals within hospitals systematically.

MS. DePARLE: That would be step number one,
wouldn't it?

Secondly, there is a debate, I gather, about
whether there is truly -- a lot of what we're saying in the
chapter and in our recommendations seems to be hinged on our
belief that based on the OSCAR data or the data that we're
looking at there's been a growth in the supply of either
LTCHs or LTCH beds. I guess we're looking at beds.

You also, Mark, gave us the letters from the
industry that seemed to argue that isn't the case, that in fact it's been flat, or they would even argue I think perhaps negative.

Why is there such a difference in the interpretation of the data or the data that we're using here?

DR. KAPLAN: I can't explain why there is such -- OSCAR is not necessarily perfect data.

MS. DePARLE: I'm shocked.

DR. KAPLAN: GAO has spent many hours writing about how bad OSCAR is.

The difficulty with hospitals within hospitals is that OSCAR isn't necessarily an accurate -- it's the best data we have. Let me start by saying that. But it isn't necessarily an accurate representation of long-term care hospitals because a long-term care hospital located in a city can open up satellites in other hospitals and other floors of the hospitals but use the first long-term care hospital's provider number. And so you would not count those other long-term care hospitals that have opened up in these other hospitals.

So it isn't necessarily a very good way of
tracking supply. I think this is kind of what Bob was getting to in that maybe looking at the rise in cases is a better representation, or the increase in spending.

And CMS, I think, is pretty conservative in the actuaries' estimates of spending for this sector because they often don't take into consideration the growth in facilities. And they are basically saying it's going up to $5.8 billion.

MS. DePARLE: So you would argue that the recommendation is based more on growth in spending than on the growth in supply?

DR. KAPLAN: I think it's all the factors. All of the factors are positive. The only one that is not completely positive is quality, which is mixed. And I'm not sure that you could say that that's related to them not having enough money in the pot.

So I would really base it on all of the factors and that you have supply, as far as we can tell, going up 10 percent. You have users going up 10 percent. You have cases going up 10 percent. You have spending going up 29 percent per year. And then you have the quality measures and you see that private equity firms think these are a good
MS. DePARLE: But you also have the margin analysis that appears to show a pretty decline.

DR. KAPLAN: Right. That's the only one that's not overwhelmingly positive.

MS. DePARLE: I guess, finally, the RTI study, and thank you for providing us with the entire 200 pages or whatever it was.

DR. KAPLAN: That was holiday reading.

MS. DePARLE: Yes, it was.

I agree with you that it's similar, in many ways, to our analysis. I guess what was disappointing, and maybe you just look at it as it confirmed what we found. But our work was done two years ago and I would like to think that it would have advanced the effort here a little bit more than it did.

So I guess I'm curious. If you were just guessing, how long would it take to take that study? And now let's have some criteria. This is what we've been arguing for several years, is that I think from our site visits -- I remember, Nick, your comment that as a clinician, talking to pulmonologists and others in some of
these communities, that you perhaps went in somewhat skeptically but became convinced that in certain communities, as a clinician, this is where you would want to get the care for the right kind of patient.

So the problem is we don't know what the right kind of patient is and we don't have criteria on that.

What's it going to take to get there? The RTI report doesn't exactly give them to us, but could you take that or could CMS take that and within a year have something?

DR. KAPLAN: I think it's possible. First of all, they've had this report a lot longer than we have because the final report, as you noticed on the cover page, is dated October 2006. So that's the final report and generally there is at least one draft before you get to final. So they've had this report longer.

My understanding pretty much through the grapevine is that they're already starting on organizing a TEP which theoretically -- to me, most of the things that RTI recommended could be handled through conditions of participation. Telling who is medically severe or medically complex, and who actually belongs in the long-term care
hospital, is the really tough nut to crack.

So I think that that's already starting and probably within the next month or so that they will be convening a TEP. And it's going to be a TEP of clinicians, is what my understanding is. And not just clinicians from long-term care hospitals, but clinicians from other post-acute settings so that you give the opportunity for clinicians who work in SNFs to say well, we can treat those type of patients. We don't need long-term hospitals for that, hypothetically.

MS. DePARLE: This seems to be one where clearly you really do run the risk of making the perfect the enemy of the good. We have nothing now and we're just moving on in the dark. And it seems to me we're way past the point where we should have gotten started on this.

I guess I would just conclude, Glenn, I sort of previewed this earlier and in my comments about the inpatient rehab facilities. My struggle here is consistency of what we're doing. I guess I'm troubled if we're making a recommendation for a zero update here, where the margins are declining, we project them to decline dramatically, yes, other factors appear positive. But that was true with
inpatient rehab, as well. These are policy judgments.

I suppose this one is defensible. I just find it inconsistent with our other analysis and I'm troubled by saying yes, I can definitely say that this should be zero and the other one should be 1 percent. It's hard to say that, especially when I think we are relying on some data that I'm not clear are accurate.

It wouldn't be the first time, as my friend Dr. Scanlon will quickly point out, but it does trouble me.

MR. HACKBARTH: Other questions, comments?

DR. MILLER: Not on your last point but on some of your other points, I think that the process could move relatively quickly to get criteria started to be put in place. The actual, I think, tough nut is the patient criteria, when you get down -- because I think there are other standards that you could put in place and begin to narrow the funnel and then start to get to the patient criteria.

Both associations have plans that they have put on the table and there's a fair degree of overlap, but not entirely. And actually, I think, both associations may choose to comment on this when we're done here.
But I think if you could get some agreement there within the industry, because there are two different industries, and this report puts some momentum behind it, you could see certainly within a year that there are additional criteria and then be driving towards the one we all really want, which is the assessment of the patient and the classification of the patient.

MS. DePARLE: There is such a thing as negotiated rulemaking. That's not a pleasant process, but you can do that. If there's a need to do something like this, that is a way of doing it. People won't win everything.

But what troubles me is using the update as the lever for dealing with what I think are much deeper issues in not just the payment system but in Medicare's benefit that it's providing.

DR. MILLER: I blacked out when you said negotiated rulemaking, having been part of a couple of those.

I also want to be sure that I leave with you that there's not so much of a difference in what we're saying in terms of growth and what the industry said. There was first one letter in which they said we're actually seeing things
going down. And we had a conversation with them and said we're looking at a different data source. And there may even been an issue of which year we were looking at. I can't remember.

And then I think a letter came yesterday that said looking at the data that we were looking at it was flat. And looking at the data that we're looking at, we see a small growth. So the distance between what we're saying and they're saying on that has narrowed considerably. Why there's any difference still, in the space of four hours when we got a letter and now, it is sort of hard to sort out. But there's much less difference than the initial letter implied, where there was kind of down and we were headed up.

You have both of the letters, the one we got yesterday we threw in there at the last minute.

MS. BURKE: One other issue, Sally, in both the context of LTCHs and the rehab facilities.

Again, I was just looking back through. One of the things, and we talked about this in an earlier discussion. One of the things that fundamentally continues to trouble me is the geographic issues that exist, in that
these tend to be in particular areas of the country. I recall in an earlier discussion the sort of question was okay, if they're that great, what happens to everybody else who doesn't have one in proximity? In this particular document there's a specific reference to the fact that proximity is one of the greatest predictors in terms of whether you're going to use this as compared to something else.

This is this underlying policy question over the long term is we're developing these sort of systems that are unique in some cases to Florida. One can imagine the population drives some of this. But I am troubled that we continue to see this kind of unique growth in very particular areas, that we are developing detailed systems, to Mark's point of trying to understand more specifically who appropriately goes into these things, but that they continue to remain largely focused on very narrow areas of the country. It's not just urban/rural. It's like three states, as compared to the rest of the country.

I don't know that there's a thing we can do, but over the long term that, to me, is a very troubling trend both here as well as in the rehab facilities.
MR. HACKBARTH: My recollection is it's somewhat more pronounced in the case of long-term care hospitals than it is in the case of rehab hospitals. That certainly raises questions in my mind.

To go back to Nancy-Ann's question, there is no analytic basis for distinguishing between 1 percent for inpatient rehab versus zero percent for long-term care hospitals. It's just a judgment. And my thinking is this: these are potentially useful for at least some patients. I am worried about the pattern of growth. I am worried about a significant expansion of the industry until we have criteria in place. And to me, in this setting, one of the few tools that we have to express that, that we think this is a go slow sector, is the update recommendation.

I would hope that the industry and CMS and everybody else involved would get on with the task of doing the patient criteria so that we can use them where they are promising and beneficial and efficient alternative for Medicare beneficiaries.

But to allow them to continue to grow in the absence of patient criteria is, I think, a questionable judgment. And so the zero is my symbolic statement about
that. I am also skeptical about the 25 percent rule and how effective that will be. So I think maybe the margin estimates are a little bit conservative in that sense. It seems like there are ample opportunities to work your way around the 25 percent rule. So I don't think that that's a very effective constraint.

I compare that to the 75 percent rule for IRFs where we've expressed reservations about that rule and how it was done and the process by which it was done. But it is at least a step in the direction of establishing criteria on how we think ought to belong in this type of facility. I think it has a lot more teeth than the stuff that's happened to the long-term care hospitals.

So that all adds up to me that it might make sense symbolically to make a distinction between the two. But I can see how reasonable people might disagree with that.

DR. WOLTER: I was just going to say, on the issue of the geographic concentration which clearly exists, there is development of these facilities now starting in other parts of the country and I think we'll see a little bit change in the map the next time we look at it. How
significant it will be, I don't know.

And then I think the obvious ultimate end game here, because as I said I think in our visits we did find some facilities where patients were getting, I believe, some superior care. But in other parts of the country those patients are being cared for as outliers in the acute hospital or in hospital-based SNFs. There may be some of them that are being cared for in IRFs and probably less so in freestanding SNFs, but maybe even there to some degree.

So the ultimate end game, if we have patient criteria, would be to compare patients in those different settings and look at where the cost/quality equation seems to be most effective. And that's very, very hard to get to but I think it's been our goal from the start on all of this. That's probably a few years out.

MS. BURKE: I recall, to that point Sally, and does remain true that at least analysis to date suggests that long-term care hospitals, when compared to acute care hospitals for the same patients, tend to be more costly not necessarily because of a difference in severity? That's what I recall from our earlier discussion, too.

Exactly to Nick's point is over the long-term the
question is where can people appropriately be cared for?

Are we paying for them appropriately, irrespective of site but based on the severity of the particular case? At least to date, at least as I understood it, long-term care hospitals were more costly, not necessarily because of a difference in acuity for the patient, between that and acute care hospitals.

DR. KAPLAN: That's what we found pre-PPS and RTI appears to be finding that. Now the multivariate analysis of that has not been published yet. There is a third phase of this study that will have the multivariate analyses. But based on the descriptive statistics, I would say that that's what they're going to find for the general patient in long-term care hospitals.

MR. LISK: The other thing that Nick had mentioned earlier though is that certain types of patients, like ventilator patients, since hospitals may only get one or two ventilator patients whereas a long-term care hospital may have many of them, they may be more effective in caring for those and successfully weaning those patients.

MR. HACKBARTH: So the crux of the problem, I think Nick, is what you've put your finger on. The map is
changing. The problem is we don't know whether that's good
news or bad news. If they're treating the right patients, expansion could be a good news. But if they're not, we're just increasing costs for the Medicare program without benefit to the patients.

So it always comes back to we need to get to the task of defining who would benefit from this expensive and intensive sort of care.

DR. MILLER: There is also one other thing that I think we'll keep our eye on as we watch this. Some of the growth that we've seen, and Sally make sure this is all correct as usual, is within the same markets. To the extent that the hospital within hospital can be circumvented by having other people to move patients among, you could get more growth. But it isn't necessarily growth in terms of expanding the availability of it more broadly to the population.

So when we look at growth for the next cycle, or as we watch it, I'm just telling you, we're going to be looking pretty hard at that.

MR. HACKBARTH: Anybody else who hasn't had a chance to comment?
Shall we turn to the draft recommendation?

All opposed to the draft recommendation? All in favor? Abstentions?

Okay, thank you.

MR. HACKBARTH: We're at the end for today. We'll have a brief public comment period with the usual ground rules.

MR. ALTMAN: I'd like to make one brief public comment.

My name is Bill Altman and I'm here on behalf of the Acute Long Term Hospital Association. I also work for Kindred Health Care, where I'm the compliance officer.

I was the one who generated the information on growth, so let me just explain what I did and be clear about what we did.

In interactions with Mark and Sally, our initial analysis using the CMS provider of service file found that in 2005, as you found, there was an increase of 28 new certified long-term acute care hospitals. And that's what was presented to the Commission.

When we looked at the provider of service file through October 2006, which is what we had access to, we
showed a net decrease of two certified LTCHs, as compared with what happened the year before. And then when we were advised by Sally and Mark that the OSCAR was available through December 18th, 2006, that's when we updated the analysis to show a net decrease of one LTCH for 2006.

so I agree with Mark that we're not far off. I also agree that OSCAR is not a perfect database but it's the best that we have.

And I think what's important is that, as compared with 2005, there was absolutely no growth in the number of LTCHs, subject to all of the qualifications that have already been discussed. And I think that is a direct result of the cumulative CMS policies with respect to LTCHs, both payment and the 25 percent rule.

I would also note that in 2006 nine hospitals within hospitals were decertified from the Medicare program, voluntarily decertified, which I think speaks to the effectiveness of the 25 percent HIH rule and the difficulty in complying.

I also point just point out, we have no difficulty in using OSCAR and the provider of service file in
identifying hospitals within hospitals. There's been a
long-standing requirement in Medicare that we report to our
intermediaries whether we have a hospital within hospital
and who the host hospital is.

CMS recently codified that in regulation, but
that's a long-standing requirement. So I think that it's
pretty easy to identify freestanding versus hospitals within
hospitals and that that should not be a barrier to
enforcement.

With respect to Mark's comment, with which I
agree, that the industry has put forward proposals to
implement MedPAC's recommendations, and it's CMS that has
not moved on this until recently through the RTI study. I'd
like to emphasize one very important point that speaks to
geographic maldistribution, which I agree is problematic and
is a historical artifact where you saw a lot of the older
LTCHs certified in the three states, Massachusetts, Texas,
and Louisiana. You do see a little bit of continued growth
even in those states.

What is really important is that the legislative
proposal that was introduced by English and Pomeroy the end
of last session, and which was endorsed by ALTHA, would
directly address that geographic maldistribution. What we did was, together with English and Pomeroy, identify the conditions that are correlated with medical complexity and say that LTCHs -- much like the 75 percent rule -- must have the vast majority of their patients in those diagnostic categories that correlate with severity of illness.

When you do that, the LTCHs that are disproportionately hit because they cannot comply with that rule are concentrated in Louisiana, Texas and Massachusetts. And the reason is obvious. Where you have a concentration of LTCHs there is intense competition for patients and LTCHs will tend to admit with loose criteria those patients that are not appropriate for an LTCH.

Our position, as you saw set forth in the letter, is that with margins approaching zero and a variety of regulatory actions that have effectively stemmed growth, that further changes to the payment system, including a zero market basket update, is not the way to get at the issues that you have legitimately raised and analyzed with LTCHs. But instead, we ought all turn our attention to certification criteria. And if we do that, we will address all of the policy issues that you have raised.
Thank you.

MR. HACKBARTH: All right. We will reconvene at 8:30 tomorrow.

[Whereupon, at 4:50 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Wednesday, January 10, 2007.]
PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Wednesday, January 10, 2007
8:38 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI
JOHN M. BERTKO
SHEILA P. BURKE
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
DOUGLAS HOLTZ-EAKIN, Ph.D.
NANCY KANE, D.B.A.
RALPH W. MULLER
WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.
MR. HACKBARTH: As we discussed yesterday, the first order of business today is going to be to vote on the physician update recommendation.

When we talked about it yesterday, a couple of issues were raised by Doug and Bill, in particular, about the impact of this year's update legislation and its rather complex nature and how it affects the language of our 2008 recommendation.

Coming into the meeting yesterday, the recommendation on the table was for an update of MEI minus productivity. And so my goal is to produce that result but explain it in a way that makes it clear in the context of the legislation that just passed.

So I think what we need to do is this: the legislation that passed at the end of last year, you will recall, had a provision for a $1.35 billion fund to be used for physicians in 2008. I think what we need to do with our recommendation and accompanying text is make clear that we think that that money, which is essentially prepaying part of the physician update for 2008, ought to be included as part of our recommendation. It's not additional money, it's
included within our recommendation. And so on that's step number two. I skipped over one, which is to make it clear that when we talk about MEI minus productivity for 2008 we're talking about basing that increase off the actual conversion factors in effect in 2007.

You will recall that the way the legislation is written it's not quite so straightforward. It provides for the conversion factors to drop. We're talking about off the higher level.

And then the third issue is that Nick has raised issues about the direction of pay for performance for physicians. And what I want to do is invite some discussion of whether we ought to add a paragraph along the lines of what Nick has been saying, that the current strategy of pay for performance for physicians, which is basically paying additional money to get all physician specialties to produce update measures, may not be the most effective strategy and at that some careful thought needs to be given to a potentially more productive strategy and more focused strategy.

I'm going to defer to Nick to elaborate on that if there are questions about it.
But that is a bit of a shift in our policy and so I don't want to add that sort of language unless there's a consensus within the Commission that that would make sense to do.

So to recap, we will have a recommendation and accompanying text language that makes it clear that our update recommendation is MEI minus productivity. The $1.35 billion is encompassed within that. Essentially, we're looking at that money as dollars to be used for financing a piece of the update in 2008.

Do people feel comfortable with that? Any questions about that?

DR. WOLTER: My discomfort with including the $1.3 billion in the update is that it's going to make it highly likely that a more focused approach to quality and pay for performance in these very early years won't happen. I think it's going to be highly likely that if it does happen then other physicians not involved in the focused approach will feel like they have been penalized because they are not included.

And so the politics of that discussion would be, I think, very, very difficult because of the way we would
include this in the update. I understand the rationale for including it in the update because that's how we've done it on the hospital side but I think it does set up a dynamic that makes this discussion difficult, if not impossible.

I was thinking about this last night. If I were the czar, I wouldn't create this fund. I'd give physicians an update. They deserve an update. They haven't had one for a while. And I would take the hospital pay for performance money that we're talking about and use that as a pool when we do these bundled DRGs, which I hope we'll get to over the next few years. And that becomes the initial focus of physician hospital pay for performance, so it's funded out of existing funds and we don't get ourselves into this dynamic of physicians fighting amongst one another about feeling penalized or either in or out of how we start in a more focused way on pay for performance.

Having said that, I know that's probably very unlikely too, given how this all unfolds. But we're really setting up some difficult dynamics now and we're creating a fairly high likelihood that we're going to have some failures in pay for performance and some backlash.

MR. HACKBARTH: Let me just make sure that Nick
and I am on the same page. I see including the $1.35 billion in the update as consistent with both our goal for physician update coming into this meeting and consistent with our past policy on P4P that it needs to be done in a budget neutral way and we're not creating separate add-on pay for performance funds for providers. For those two reasons I think it's very important to include the $1.35 billion.

I am prepared to open the door to talking about a more focused physician strategy of the sort that you've described and we can take that up in the next cycle and think carefully through what the implications of that are and how it ought to be funded, et cetera. I don't want to do that, create a separate fund, endorse a separate fund by the seat of our pants, without thinking it through.

So I'm willing to go so far as a paragraph saying there needs to be some strategic rethinking of physician P4P, but I'd really prefer to stop there.

DR. WOLTER: I'd be very happy if we included a paragraph that just said the option of a more focused approach in the early years to physician paid for performance, perhaps tied in some synergistic way to
hospital measures -- just even if we put that, I think it would be a step ahead of where we've been.

But I will say this, you're absolutely right. What you're recommending is consistent with our past statements. Our past statements, however, have not set us up for the most well thought out tactical approach to how we might do pay for performance.

MR. HACKBARTH: And that's the conversation I'm willing to have.

DR. WOLTER: That's the problem we've created for ourselves, I think.

MR. HACKBARTH: I'm willing to stipulate to that and that's a conversation we need to have. But let's do it in a thoughtful way, as opposed to by impulse confronted with this situation.

DR. WOLTER: I totally agree with that, too. It's just now we have this dilemma of these dollars that got funded that are putting us in this position of including it in the update, increasing the likelihood of a more diffuse approach in the early years.

MR. HACKBARTH: Let's get some other people in here.
DR. HOLTZ-EAKIN: If I understand, I'm not sure that has to be the case. It's not like these are earmarked for P4P purposes. They can just be for the update. So I guess that's one possibility for the way it could play out but I don't see why it necessarily has to be that way.

DR. WOLTER: I don't think it has to but I'm thinking of the politics, like you all do, about what might happen when one group feels left in or out. That's all.

MR. HACKBARTH: Unfortunately, the record on exactly what was the intended purpose of the $1.35 billion is murky. We just don't know that.

As I think Bob noted yesterday, 2008 is an election year. So one very simple notion of what was intended was to assure there's going to be some update in a presidential election year. It has nothing to do with P4P, but basically pre-funding some update.

So what the purpose was we don't know. I think we should not assume, however, that this was intended to be or will be used as some sort of special P4P fund.

DR. KANE: I actually think I would take it as an opportunity to direct it toward the infrastructure rather than P4P, because -- towards anybody who starts to form an
accountable health organization or develops the
organizational structure or the information system
structure. I know you don't want to pay for information
systems themselves.

Just putting together an accountable health
organization takes money and funds. So I would think it
would be, since it's not earmarked and it's not necessarily
part of the update, and you don't really want it to go to
P4P right away. But what we don't have is an intermediate
step of who do we really want to pay? We want to pay
organizations that span much broader provider scope that
just the physician.

But to do that they've got to reform all of these
PHOs and IDS's and other forms that they might come up with
and it costs money. They need to hire people.

So I would think the $1.35 billion is an
opportunity to really jumpstart the infrastructure for a
meaningful P4P in the longer term and I would just take
advantage of the fact that nobody knows what to do with it
yet.

MR. HACKBARTH: I wouldn't say that. It's easy to
conjure up ways that we could spend more money and I don't
think we ought to just leap on this and say well, let's on
the spur of the moment come up with a new idea on how to
spend it.

DR. KANE: That's much more strategic than just
dumping it into the update and doing P4P before we know what
P4P is supposed to be.

MR. HACKBARTH: I'm not even sure what your idea
means.

DR. KANE: We've been talking about accountable
care organizations for the whole time I've been here. And I
think it takes money to build one. And I think these things
don't just materialize because you've imagined them. So
that's where I think it would be helpful to get them
started.

MR. HACKBARTH: I do understand the concept, but I
don't understand in practice what it means. And I don't
think that on the spur of the moment again we ought to
endorse some broad concept.

I'm happy to discuss it. I'm happy to think it
through, discuss pros and cons for different ways to use
money. But I don't think we ought to just say oh, we've
discovered yesterday this peculiarity and we ought to spend
$1.35 billion.

MR. BERTKO: Two comments, one to put some structure under what Nancy just said and to agree with her and to say I think we like to -- and again, this is not meant to be spur of the moment, Glenn, but just as a possibility. Connectivity as being the result here, and there are real-time clearinghouses now available and physicians may just need a spur to sign up for them. That's one part.

The second one I certainly agree with what Nick has expressed here in terms of focusing on the P4P parts that would have the most bang. But I also know that in working with Beth McGlynn in particular, she has shown us at least something like 20 or 30 specialties which have probably mostly process measures that could be looked at. And maybe this again is just something that we should look at a little bit in our next cycle and perhaps offer some comments and advice on, in terms of what's out there that's readily doable and then for folks like Nick and Jay and our other physician colleagues here to say what's the best choices among these.

MR. HACKBARTH: So you're saying, John, that you
would prefer not to have the paragraph along the lines that Nick described?

MR. BERTKO: No, I think the paragraph is a good idea and it may be up for us -- I mean in my mind there are half a dozen competing quality organizations out there, all with their own ideas. For us -- I think what could be one of our jobs for Medicare is to say here, let's sort through some of these and pick the best that we think are straightforward and then hand it back to CMS to take action on it.

DR. WOLTER: I just would add, I really agree with this. I don't think the idea of focus has to be exclusive. But I think within what we're doing it has a lot of merit. But there are some specialty societies doing good things and we just need to put that all together.

MR. MULLER: Cristina, could you go back to the kind of step chart you had yesterday? Because I want to talk not just about the $1.35 billion but the quality pool, as well. The one that has the quality pool in there, as well. I want to make sure I understand the base for -- don't you have one that has both the $1.35 billion and the quality pool?
Glenn, in terms of where you were 10 minutes ago,
I'm understanding that you want the $1.35 billion fund to be
considered part of the pool of funds that we would be
recommending for 2008. The 1.5 percent is just a 2007 item.
So in that sense it falls off that cliff and there is not to
-- I just want to make sure we understood it.

DR. REISCHAUER: It will be a lump payment in 2008
to those who did the right thing in the last half of 2007.

MR. MULLER: Yes. So in terms of the consistency
of our thinking, I share some of Nick's concerns that we may
be consistent but we may be off in terms of this.

I think we should, based on our past
recommendations, keep going with the kind of MEI minus
productivity as we have and take the $1.35 billion into
account. And the extent to which we get into a more regular
cycle of doing that, especially in light of our SGR
conversation yesterday, I think being consistent with our
past recommendations and have a MEI-type recommendation each
year, I'm in favor of that. I've argued that the lack
thereof spurs other kinds of behavior that I think have more
effect on expenditure than, in fact, the update does because
I think the utilization increases are somewhat driven by the
lack of an update. So I'm in favor of continuing to go in the
direction of an MEI-type recommendation.

My sense is that that 1.5 percent will be seen as part of the base because the 5 percent, the yellow there, is just basically adjusting for the SGR cut. So my sense is people will see the 1.5 percent as part of a new base. That doesn't mean that we have to see it as part of a new base, but my sense is that they'll see this not just as a one-time thing.

So I think having a recommendation on the MEI is the right way to go and I would endorse putting the $1.35 billion -- I just wanted to make sure I understood how the 1.5 percent in the white there fit into the closing of that, keeping that step at the 2007 level.

I think that what Nick and John have suggested, as we know from our past discussions about pay for performance in the physician community, all the solos, all those 57 percent of the people who are in solo are just not going to be able to play in this game anytime soon.

Therefore, the fact that if we have P4P and it goes to a less than a majority of the physicians, I think
it's a policy statement that will, as Nick said, cause some
real divisiveness inside the physician community.

Like you, I don't have an answer to that. But I
just don't see the solos being able to play in the quality
reporting very easily, for the reasons that Nick and John
have mentioned or Nancy. It takes a bit to just get up to
gear to report, and many of them do not have the capability
inside their office to do so. It often takes the lumpiness
of adding on another staff member to do it and they're not
going to see that as worth the expenditure for the 1.5
percent.

Not to reprise all the arguments, I think one of
the real challenges we have is we don't have a way to get to
100 percent of the physician community in P4P anytime soon.
I think explicitly acknowledging that is a helpful part of
what we can say that is consistent with what we've done in
the past.

DR. CROSSON: One approach that might, I don't
know whether to use the term straddle or be inclusive of the
comments, if we're going to include the $1.35 billion, would
be to refer in that back to the other report, to the SGR
report to Congress, and say something like were Congress --
because we have this whole section on a phased approach to
improving physician reimbursement.

So it might be possible to say Congress should
strongly consider the use of this money to, in some way,
advance the recommended agenda for a phased approach which
would actually include all of these ideas, make the point
that the money ought to be used in some way to improve
physician payment over time but not have to make a choice at
this particular moment about which ones of those things
might be the best approach.

MR. HACKBARTH: Although we've not, in fact,
recommended the phased approach.

DR. CROSSON: No, but if Congress were to consider
that pathway, something like that.

MS. BURKE: I'm a little confused. As I
understand it, Glenn, what you're proposing, following up on
yesterday's discussion, is in the absence of clarity as to
the intention with respect to this money that it simply be
considered a pool of money that, in fact, would be
incorporated into the market basket update.

MR. HACKBARTH: Basically a prepayment of the
update.
DR. REISCHAUER: Help pay for it.

MS. BURKE: Help pay for it. But as I understand what you're saying, Jay, is to essentially revisit some of the fundamental questions we ask in the SGR report and suggest it be used for something else. I think that's at direct odds with what Glenn is suggesting, I think.

I think what Glenn is suggesting is absent any Congressional intent that was clear, which is what we asked yesterday and they haven't been able to find anything, that we have to assume that it was presumed to be available to make sure that there was the resources available for an update, as compared to using it as part of a tool to do something that is more targeted; i.e., in the P4P.

I'm not disagreeing with you that over the long term Nick's concern is that if we do P4P that we need to be more targeted as we go forward. But I think what Glenn is saying is absent any other clear direction, these funds are presumed to be available to help finance the market basket, which is for everybody.

MR. HACKBARTH: I agree with all of that. As I said, if we want to talk about how we could use additional funds, whether it be $1.35 billion or some other number, to
advance the phased approach or to advance the development of
accountable care organizations, or to advance connectivity,
we can do that. But let's do it in a thoughtful way.

And right now where we are is we came into this
meeting trying to make an update recommendation of MEI minus
productivity. And I'm just trying to reconcile that with
this more complex framework. I think the way to do that is
count the $1.35 billion as basically a prepayment of the
update for 2008. And then we can discuss the other ideas in
due course and do so in a thoughtful counsel way.

DR. WOLTER: I guess I just came away with the
impression that there was some language that this $1.35
billion was linked to quality. So if that's not the case, I
certainly would agree with your logic.

DR. SCANLON: I just want to reinforce where you,
which is this is 2008 money. And to come up with a new idea
in terms of how to spend it well, we're too late. In terms
of keeping it as part of the update, we've got a framework.
We can use it there and can fund this. The good ideas need
time to develop so that they can be implemented well.

MR. HACKBARTH: Any other comments?

What I'm taking from this discussion is that
people do support adding a paragraph of the sort that Nick
described. It would be in broad terms, we need to think
about the strategy for doing physician P4P.

MR. MULLER: But my understanding is that 1.5
percent is one-time quality money.

MS. BOCCUTI: Just for reporting.

MR. MULLER: But I mean that's basically where P4P
has been for awhile, has been on reporting.

MS. BOCCUTI: That's the way the law is now. It's
silent on what would happen in 2008 with regard to reporting
or performance incentives.

MR. MULLER: Next year I understand that once you
put it out there some people will think it's part of some
base. In that sense, while it's not formally part of our
recommendations, and I don't think we need to speak to it,
I'm sure next the Commission will have to.

MS. BOCCUTI: It may not seem so much part of the
base. I think what you're saying is you could even imagine
this being -- instead of the 10 percent, being 11.5 percent,
is what I think you're starting to go towards.

But because it's a one lump sum payment in 2008 it
might not be perceived so much as part of the base.
DR. REISCHAUER: And also, a fraction of physicians are going to get it and we don't know what that fraction is.

MS. BOCCUTI: We don't know that. And I think that physicians are trying to get measures in, so that most physicians will be eligible. But we don't know that yet.

DR. REISCHAUER: But I think, as Nick or somebody said, for many the cost of doing this will be greater than the benefit that they get from the lump sum so they may not be incentivized.

MS. BURKE: I think it will be very important to the extent we can, to find out exactly how much was spent, if they did the full payout in 2008, and what they spent it for.

The language which would suggest to the extent feasible still makes me nervous because you can use that to say well, it wasn't feasible to do X. So I think ultimately, for the Commission going forward, understanding whether there was a payout in 2008, what the nature of the payout was, and how they structured the payout will be quite informative.

MS. BOCCUTI: Payout for the $1.35 billion or the
1.5 percent quality?

MS. BURKE: No, the 1.5 percent.

MR. MULLER: But the 1.5 percent, that's not a pool. You can get 1.5 percent for reporting.

MS. BOCCUTI: Right, but we don't know how much that will total, because it's 1.5 percent on all the services that the physician provided that meet the threshold requirements.

MR. MULLER: So if my speculation is I say half can't do it, then it's 1.5 percent for the half that can.

MS. BOCCUTI: Right. So we don't know the total sum for that. I think that's what Sheila is answering, is how much did that sum up.

DR. MILLER: Sheila's point had to do with the $1.35 billion.

MS. BOCCUTI: No.

DR. MILLER: Then I need to clarify what you said, that the to the extent feasible applies, that language, the $1.35 billion feasibility language applies to the $1.35 billion.

MS. BOCCUTI: Right. That's why I asked. But the $1.35 billion dollars has no restraint, other than it can
only -- I mean, to the nth degree it can only be 1.5 percent of all services provided.

MS. BURKE: [off microphone] So again, I think the question will be -- and thank you, that helps.

But understanding ultimately how they choose to do it, what the decisions are, and what they spent will be quite useful to understand.

MS. BOCCUTI: We'll try and find out from CMS how it's going and what they're doing. I think everybody will be interested in it and we will track that.

MR. HACKBARTH: Let me just have a show of hand of people who have comments.

Before we take those, I just want to go back to something Nick said a minute ago, just so there isn't confusion. In reference to the $1.35 billion, Nick, you said that -- and I can't reproduce the exact words, but something about you thought that there was language about being used for quality. I want to just make sure we're all on the same page as to what it says.

There is language that says that it may be used by the Secretary for quality -- can you quote the exact language. Quality is in that phrase.
MS. BOCCUTI: They attached that to the name of the fund, but it is not technically required to be used for quality.

MR. HACKBARTH: Right. So it's listed as a possibility but not as a requirement. Then the separate question is what do we know from the legislative history, the intent of it, and that's the piece that is murky. So it's basically up to the Secretary how to use that money.

MS. BOCCUTI: It's called the Physician Assistance and Quality and Initiative Fund. And so I think that's where we're getting the quality term for it. But it's not technically directed only towards quality measures. But the term is linked.

DR. MILLER: The legislative language says that the Secretary can use it either for payments or for other initiatives.

MS. BOCCUTI: Correct, and I'll get that specifically.

DR. CASTELLANOS: This is on the 1.5 percent. To stress Bob's point and Ralph's point, not all physicians are going to be able to do that because they're not going to
have the technical ability to put that on the bill.

But more important, even physicians that want to
do it, unless their society has put in quality measures --
and that date is they need to do it by January 31st -- even
if you want to do, if the society hasn't done it you're not
going to qualify. And there's about six societies right now
that have not done it.

Which speaks to Nick's point. I don't think the
whole medical community is ready for P4P. And if we're
going to make P4P effective, we need to focus it to a
certain area that is ready to be done.

MS. BOCCUTI: I have the language.

The Secretary shall establish under the
Subsection, a Physician Quality Initiative Fund, which shall
be available to the Secretary for physician payment and
quality initiatives which may include application of an
adjustment to the update of the conversion factor under
Subsection D.

DR. REISCHAUER: I looks like we put it in the
right place.

MS. BOCCUTI: It says available for physician
payment and quality improvement initiatives, which may
include...

MR. HACKBARTH: The bottom line is the Secretary has broad discretion on how to use it.

MR. DURENBERGER: Can I just make a comment on this? I think most of us know that the Secretary has spent a good part of the last year bringing the hospital quality and the ambulatory quality people together. He's visited a number of communities around the country encouraging physician quality initiatives where they already exist.

I am presuming without knowing that part of this language derives from the Secretary's effort to encourage existing physician-based or physician-initiated quality projects. I think that's part of the explanation.

MR. HACKBARTH: He may elect to use it that way. I consider him a kindred spirit, somebody who is enthusiastically a believer in quality improvement and the like.

But the fact of the matter is it is going to be an election year, the budget is going to be tight, particularly if the PAYGO rules are instituted, and money is going to be scarce. And the path of least resistance is to use this money to fund an update.
But how it plays out I don't know. Time will
tell.

DR. SCANLON: I'm fully supportive of what Nick
has proposed, in terms of how we should be moving forward
with physician pay for performance, this idea of being
universal is really a handicap.

But he's also pointed out the potential
contradiction between that and our policy of budget
neutrality, because it implies that people who don't have
the measure that we want to reward today are, in some ways,
poor performers.

I guess there's a question of how we get that in
this paragraph in a clear way and consistent with our prior
policy.

Part of it may be that the issue is what's the
budget that we're trying to be neutral toward? Is it just
one that's going to be increased for inflation? Or in this
instance are we willing to have some pay for performance
built into this budget?

When we first talked about physician pay for
performance, we were talking about the experience of Britain
and how they had introduced, seemingly successfully, pay for
performance for physicians. But it was all new money. And it was targeted on primary care physicians.

But again, it was in the context of putting in a new investment. So it's very different than trying to say our budget is only going to grow with inflation and we're going to reallocate it.

MR. HACKBARTH: I think that's well put, and I think that is one of the central problems here in moving from a broad strategy and P4P for everybody to a more focused one, is how do you finance it equitably? Do you tax everybody when only a subset can potentially benefit from the incentive payments? And so I think we need to think that through. Maybe it requires an adjustment of what we said in the past. I just want to think it through.

Bob reminded me yesterday that the IOM Committee that he chaired on this said that -- why don't you go ahead and say it, Bob.

DR. REISCHAUER: We struggled with this issue and played around with several options. One is a temporary infusion of new monies.

But another one is to take the procedures for which one has the measures that one is going to apply and
nick all of them and redistribute the money according to
performance among them, and not touch anybody else. The
difficulty there is then you create an incentive for people
not to move forward. So you have to have some inevitability
that at some point they're going to be part of the game,
even if the measures aren't available now.

I think what Nick is pointing out quite usefully
is that it may not be worth the effort for some things, both
the measures aren't that meaningful, never will be that
meaningful, the amount of money isn't that great, and the
administrative costs of doing it just sort of outweigh the
gains you have.

And I think all of that is the kind of thing that
we should struggle with next year as we say really what are
the next steps in the physician area as we try and move
forward. Because I agree wholeheartedly with you, that by
trying to do one size fits all or everybody's in the game
immediately, there's a very good chance that you're going to
create so much opposition and confusion that the whole thing
gets thrown out.

MS. BURKE: Bob, I'm sorry, do I understand you to
say that in the course of the IOM's work that they got to
the place Nick was ultimately, which is -- as I understood you to say it -- there may, in fact, be a point at which there are certain things that are not worth --

DR. REISCHAUER: No, we didn't get to that. The Committee actually said that in the by and by, everybody should be part of this thing.

MS. BURKE: Because my understanding of Nick is there may be a point at which any number of things may suggest that there is a tail that may not be worth the expense to bring the tail in.

DR. WOLTER: Yes, although the thing that intrigues me the most is the other side of that coin, which is where are the high volume, high cost areas we could really create some improvement on in the early years? That's the exciting part of all of this.

And if we lose the chance to tackle that because we're dealing with all of the other stuff that would be too bad.

DR. REISCHAUER: The other thing is that initially, in the IOM view and I think in our view too, that this starts as a siloed kind of exercise. But over time what you're really interested in is outcomes, episodes of
care, where the bundle of providers is larger and can
encompass everybody. And how the money is allocated among
all of the players is something that's way too complicated
for mere mortals to decide at this point.

But this would be, in a sense, just a transitory
phase.

MR. HACKBARTH: Okay, I think it's time for us to
move ahead. So would you put up the recommendation?

And then the language explaining the base that
that increase is off will be in the text, as opposed to
trying to incorporate it in the actual boldface
recommendation. And then the language that we've just been
discussing, that Nick has suggested.

All opposed to this recommendation? All in favor?

Abstentions?

Okay. Thanks, Cristina.

We are now officially done with last year's cycle
and moving on to a new cycle.

MS. CHENG: So let's switch gears a little bit.

What we're now talking about is a Congressionally mandated
report. This is due in June so we're still in the
preparatory stage and I'm going to bring these issues and
these issues back to you a couple of more times before we write this report.

So I just want to get one concept. I am going to give you my take way right at the top, which is as we look at measuring quality, we have to acknowledge that in any measurement of the quality of a provider you've got a certain amount of noise. And what that noise argues, I think, is that the statistical significance of differences that we measure may be important. That's the idea I want to play with this morning. Let's see where that takes us as we think about pay for performance.

Congress asked us in this report, due in June, asked MedPAC to think about four questions. The first one is how should we fund pay for performance, and we just talked about that so that's pretty clear.

The next three then are how should we set thresholds for rewards and penalties? What's an appropriate size for a reward? And how should a program of rewards balance rewards for improving your quality from period one to period two against attaining high quality in our measurement period?

So we've been working with contractors, they're
called OCS, Outcome Concept Systems. They're a national private quality benchmarking firm. We've gotten two years of the most recent data that we could from CMS. Actually, it's a pretty good set. It brings us up into the end of 2500. So we're looking at pretty recent data to tackle some of these questions and start our thinking on them.

I want to start this morning by getting pretty concrete, so that we've got a good base to build on.

What is the home health outcome? What are we talking about when we're measuring the quality of home health? So measuring the home health outcome starts when a nurse or a therapist measures the patient's function at the start of care.

So for example, Mrs. Jones returns from the hospital after a stroke and she's being admitted in her home to a course of home care. When she is assessed at the start of care, this patient is unable to get to the toilet and uses a bed pan. Then over the course of her care at home, the patient receives supportive and therapeutic care from a variety of professionals, aides, nurses, therapists, and others while the patient is homebound.

Then at the end of the course of their care, and
this might be two weeks later, two months later, when they are discharged from home care, the nurse or the therapist uses the same tool to then measure patient function again at discharge.

So what we're after is what was the change in the level of function during the course of home care. And in this example perhaps now Mrs. Jones is able to get to and from the toilet without assistance.

So the terms of a home care outcome measure, what we're measuring here is the level of function, improvement in toileting. And for this patient this would be scored a yes. Any improvement from a lower level of functioning to a higher level of functioning -- and on this particular ADL there are five levels of functioning -- would be scored as an improvement. If the patient stays at a level of functioning other than the lowest level of functioning, then we could score that as stabilization. So you've got another measure here, improvement in toileting, yes/no; stabilization in toileting, yes/no.

So this is how the current system works. This is data that's already collected. A lot of this data is used to measure quality. It's also used to run the case-mix and
the payment system. So this is data that's already in the
flow, being collected and analyzed by the home health
gencies and by CMS.

DR. REISCHAUER: Is it audited?

MS. CHENG: To the extent that it runs payment, it
is subject to payment audit. So yes, there are edits at the
regional home health intermediary level and the OIG and
others look for fraud and patterns of abuse in the payment
as a claim.

DR. MILLER: But Sharon, it's not broadly audited?
The percentage of records pulled and things like that?
Aren't there some questions about how accurate the data is?

I do know that there are some oversight and some
automatic editing that goes on, but I don't want to leave
the impression that this is all heavily cleaned and reviewed
data.

MS. CHENG: Right, and it's shades of gray here in
home health.

DR. REISCHAUER: It's a judgment call, it strikes
me, a lot of it. It's very difficult.

MS. CHENG: And when we, as a Commission, are
approaching home health, for the last four or five years
we've been talking about home health cost report data. And I think what everybody has internalized is that the rate of audit on cost report data is near zero. I don't want to disabuse you of that issue.

But this is a different stream. The data that we're talking about runs the claims for payment. So in terms of automated edits, almost all of this data goes through automated edits like any claim for a payment from a physician from a hospital.

And then there is a very low but typical level of then targeted review, pulling 1 or 2 percent of the claims, and looking for an additional level of automated edits and audits. And then a small proportion of that would be kicked back for medical record review or something like that. But it looks like a stream of claims for payment.

DR. SCANLON: When the fraud and abuse efforts were more intense, we were still talking about 1 to 2 percent of claims ever getting anything more than the automated review. And the reality about automated reviews are that once you understand what's going to get kicked out, you don't have to ever have anything kicked out again. You can develop the knowledge that makes your claim consistent
with their edits. That's the concern about this.

MR. HACKBARTH: I don't want to get bogged down on this point, but it is a critical issue in terms of the reliability of the data.

It's also one thing to audit a claim, and basically the question is was a person at a particular place and time? Was a home health aide present and caring for a patient? It's a little more difficult to verify improvement in toileting, looking back. It's a different sort of question with different evidence required.

Why don't you go ahead.

MS. CHENG: So what we just looked at then is how we would go about measuring one patient on one outcome.

So for our work to address designing a system of measurement for the quality of an agency, then what we want to do is bring multiple assessments of patients and multiple patients at an agency together so that we have a measurement of the quality of the care for the agency.

What we've developed for purposes of working this idea through is a measure that assesses each patient's total ability to function with about 20 different indicators such as the toileting example that we just looked at, walking
around, managing oral medications and a set of functional
outcomes. Points are scored then for improving or
stabilizing the functional level of the patient and points
are lost for each potentially avoidable adverse event. We
have a set of four potentially avoidable, unplanned
hospitalizations and use of the ER.

In this model, those measures are doing a little
bit of double duty because not only are they telling us
about the patient's ability to remain safely at home but
they're also giving us a sense of the efficiency of resource
use for the program's resources because an unplanned
hospitalization triggers the use of other resources within
Medicare. So we're getting a little bit of a sense of
whether the care is resulting in the best use of program
resources.

We then take this information together and we get
an agency score. The maximum score on our scale is two.
Agency scores in our dataset tend to range from about
negative 0.2 to two.

So what do we do with the agency scores and how do
we use them in a process of pay for performance and agency
quality measurement? This is a fairly familiar approach and
it's got some real strong intuitive appeal. We could take all of the agencies that we've got in our performances set and we could rank them according to their quality score.

On the screen you've got a handful of nine hypothetical agencies. They've been ranked by their quality score. We can draw two fairly simple lines. The first line tells us the top 20 percent of performers and they would be in the reward group. And then the bottom line tells us where you would draw a line for the bottom 20 percent. And then you could imagine putting them into the penalty pool.

This is very intuitive. This is the kind of information that you can access now. You can find out, for example, on CMS's Hospital Compare what the percentile ranking of the hospital is for a score.

By design, doing this kind of threshold drawing ensures that you're always going to have a pretty substantial group of agencies in the reward pool and a substantial group of agencies in the penalty pool. You've designed that into the system.

The disadvantage that I see in this approach is that it depends on ranking agencies. The nine that we've put up here have pretty nice big gaps between their scorers.
But in reality you would end up, in a system like this, making a lot of distinctions where you might not see a whole lot of difference in the scores.

The other disadvantage to this system is that when you're participating in it, as an agency if I tell you at the beginning of the performance period, this is going to be my approach to scoring you, you don't know necessarily want your rank would be in the nation. And you don't know where that line is going to be drawn. So I can't tell you at the beginning of the performance period what it's going to take to earn an A or what it might take to fail the system because we don't know those scores ahead of time.

There's another disadvantage, and I'm going to go to this graphically because you can't see it here but I think if I can draw you a picture it will pop out.

What we found when we applied this concept to real data is a picture that looks something like this. In your mailing materials you had a figure that was pretty sloppy but it actually had 4,000 points of real data. This is just a handful of agencies that are not particularly representative. But the agencies whose dots there are sort of the pinkish-red would be the penalty pool. They have the
The lowest 20 percent scorers. The ones that have yellow dots would be in sort of this no effect zone. And then the green dots would be in our 20 percent reward.

But I've drawn a line there according to the size of the agency because what pops out to me is that if you're very small you have fewer than 100 patients that we can measure for the entire year, there's a lot of variation down there. That's where the lowest scores are and highest scores are. And if you look then upwards towards the larger agencies, almost none of those larger agencies get out of that no effect box.

What could be the case is certainly this could be measuring performance. It could be the case that large agencies tend to be middle of the road and small agencies tend to be very poor or very good. But what we wanted to look at when we saw this pattern was whether or not what we're really capturing here is noise in our ability to measure the performance of small agencies.

What you're not seeing on this picture, I've taken out agencies that have fewer than 25 patients in our sample. But you would put a big mass of dots right at the bottom of that and they would look even messier than the dots that
I've got up there for you.

So what we did when we saw that pattern in the data was to take sort of an alternative approach and apply the concept then of the statistical significance of our quality measurement at the agency level. We felt that agencies with very small numbers of patients -- and there are many of them -- are more likely to vary from the mean due to luck of the draw and not necessarily because their true score varies from the mean.

So we calculated a confidence interval around each agency's score. So larger samples, where patient level outcomes were consistent, would increase our confidence that the mean observed score was a true measurement, and smaller samples with inconsistent patient level outcomes would decrease our confidence that our observed mean was the true score for the agency.

Now when you look at this graphically you get a somewhat different picture.

So the concept would look like this. The intervals here illustrate what we measured to be the noise in our quality attainment scores. The square yellow box there is the observed mean score for each of the agency --
again this is just a handful and now we've got hypothetical agencies up here.

So the mean score for agency A there, way on the left-hand side, would be 0.4, and the confidence interval around that mean estimate varies from 0.3 to 0.5. And I've arrayed my hypothetical agencies here.

What I'm trying to communicate as the concept is that for some agencies our confidence in the mean score is pretty tight. We've got a very small interval around them. But for other agencies that are smaller or have inconsistent scores, we might have a lot of uncertainty about the trueness of that mean score and whether or not we're really getting a good measure of the quality of the agency.

What I'd like to play with this morning then is using this concept to set thresholds and to assign rewards and penalties to agencies. So let's take this idea, the mean score and the confidence interval. And now we're going to apply the national mean patient level score.

So for this outcome the mean score was 0.82, and I've drawn the line now across the set of agencies. So what I'm trying to show, again the red would be agencies in the penalty group, yellow would be in the no harm box, and the
green then could qualify for a reward. So the way we would set the threshold would be to measure whether or not an agency's score is significantly statistically different from the mean.

So these guys, although their measured score is a little bit above or a little bit below the mean, what the interval around each of those dots tells us is that statistically it's indistinguishable from the mean.

The disadvantage, I think, of this system is that it's somewhat less intuitive than our first fairly straightforward example. You also come up with some outcomes that are going to be a little less than intuitive. Let's look at this pair of J and K. The observed mean score for agency J is a little lower than the score for agency K. But K here, because of its confidence interval, would be classified as the same as the mean and J would be classified as statistically significantly higher than the mean.

While this is somewhat less intuitive, I think that this is a concept that we can communicate. This has been used in other forums. The Minnesota Community Health Initiative uses the concept of an estimate and an interval around the estimate to communicate in public reporting, in
The AHRQ is also contemplating using intervals and confidence intervals in its next national health quality report to get this idea across that quality measurement has some noise and we should acknowledge uncertainty where we know that it exists.

The advantage, I think, of using this concept in our quality measurement system is that we can include small agencies and large agencies. We can put them on the same scale and we can assess what we know about their quality and we can make measurements and comparisons of both large and small.

Also, we can set this system with the national mean from the previous year, so everyone knows the mean going into the system. So you know the score that you need to beat to get into the reward group and you could know the bar that you could fall below to run the risk of getting into the penalty group. So there would be some more knowledge on the part of the providers of what score they've got to attain to get into these groups.

One disadvantage though, from the program's point of view, of setting the bar beforehand is that this system,
unlike the other system we were looking at, doesn't ensure that you're always going to have a large number of agencies that fall below into that penalty group or that you're going to have a substantial number of agencies that are going to be high enough to get into that reward group.

So you're not building by design into the system a certain number of agencies in the reward or in the penalty group. So that was a pretty big concerned when we were looking at this system, so one of the things we did was to go back to our data. We measured, using this system, whether or not, at least in our measurement years, we would have enough bodies in these pools.

What we found is that when we measured our agencies, and we included everybody down to the smallest agency and up to the largest agency, that many agencies did fall into the reward and the penalty groups. Between 14 and 29 percent of the agencies would fall into the penalty group and between 18 and 34 percent of agencies would be eligible for rewards if our test was statistically significantly different from the mean.

Just for a little bit of a stretch, you could use the same concept that we've used up to this point for
measuring attainment and we could apply it to our
measurement of improvement. Throughout the presentation
what we've been focused on is measurement of attainment, the
level of quality attained by the home health agency in our
measurement year. But we also want to include agencies that
are getting substantially better. So our approach could be
to test then, using the same statistical method, whether
year two performance is statistically significant higher
than year one performance.

What this does again is it biases the system away
from rewarding noisiness in unstable measures and it
accounts for the noise in the measurement when we're
comparing performance across time.

What you can find however, when you're testing
statistical significance, is that sometimes numbers that are
small are significant. And so you could conceive of a
system that uses statistical significance but also has some
kind of threshold, some minimum amount of absolute
improvement before we would say that you are different
enough in year two to merit a reward of some kind.

So one of our challenges, this was the last
question then on that list of questions from Congress, was
how do you balance improvement in attainment. This is just one approach but it gives us something to think about.

You could bring these two concepts together and you could then give a full reward to agencies that are statistically significantly above the mean. You could give a reward that is half that size to agencies that are statistically the same as the mean but show statistical significant improvement.

You might put then, into another group of no impact, agencies that statistically are the same as the mean or perhaps agencies that are below the mean but show statistically significant improvement from year one to year two.

And then finally, in your penalty box, you could put those agencies that are both below the mean and not showing improvement during your period of measurement.

So we've accounted for noise. We've looked at ways to bring attainment and improvement together. We're still going to have a challenge in home health, and in many settings in fact, of what do we do with the small actors. We've set up the system so that noise isn't measured, so probably small actors are now going to be less likely to
receive these rewards because they're going to have to show statistical significance. So how do we get them into these groups? Here are two proposals that we could consider as we develop this idea.

The first one would be to allow voluntary quality associations. What you could do is maybe in a geographic area or you could allow them to organize themselves. But before the period of performance, a group of small providers could agree that for purposes of measurement they would pool their patients. They would form this voluntary association. And then we would count all of their patients together and the sample size would be more likely to qualify them for a reward. It would also be more likely that they would get a penalty. But it would allow them to participate and to have excellence among small agencies rewarded.

Another approach that I'd like to suggest we think about is pooling data across two years. Conceptually, a lot of these systems run on data from one year. But we found that you get a lot of bang for the buck if you're willing to go for two years of data.

It also has the advantage of taking out some of the noise in measurement. That's just caused by effects
that are going to happen over time. A change in ownership, a bad flu epidemic. If you've got a little bit more data to play with, and you take a little bit more of the variability out, and you might get a better true measurement of the quality of the agency over time.

In this system, that wouldn't necessarily delay the implementation. We've got five years of data so we could easily look back one year from our performance year if we're going to pool data across multiple years.

A lot of stuff to chew on. I think we could have a good discussion. Our next steps then would be to discuss these ideas of thresholds, attainment, improvement and measurement, and then take some of our ideas and consult with outside experts on quality measurement. And also with stakeholders, kind of kick the tires on this and get some reactions from that group.

Then I'd like to apply the lessons that we've learned from this example of designing the home health system and apply this model to addressing the mandated questions for home health. But also to the extent that we can, to comment on the broader questions of design for pay for performance.
With that, I'd like to open the discussion.

MR. HACKBARTH: Just one clarification, Sharon.

In previous discussions of this we've talked about issues surrounding developing composite measures of quality. In this presentation I think you've focused on a single example. What's the significance of your just focusing on a single measure? Have you concluded that that's the way it ought to be done as opposed to with composite measures of quality? Or have you just consciously set the composite issue aside and we'll come back to that later?

MS. CHENG: Certainly for the purposes of the presentation, I've put all of those questions aside. In the mailing materials we walked through two alternatives that we still have that are available for us to look at that are slightly different composites. What we have been looking at is a composite, it was just the one that is most easy to manipulate. It has some nice characteristics of validity and reliability. But by no means have we closed the question of how to develop that measure.

MR. HACKBARTH: I just wanted to clarify that.

Questions, comments?

DR. SCANLON: I have a couple of comments. One, I
think this relates back to our discussion yesterday about home health payment and the payment system. I think, home health is a somewhat different case and yesterday's margin distribution kind of brings this forward. If I'm an agency and I'm thinking about the business case to see if I can qualify for a pay for performance reward, I think I have to consider what is it going to cost me to achieve the outcomes that are going to be rewarded? And if I'm at a 35 percent margin, maybe I'm doing fine compared to any reward that I could possibly get. Or I don't even need to worry about the penalty that might be associated with that.

So it's a question of grafting a pay for performance incentive on top of a system that may have some fundamental flaws of its own and the combination is not going to serve us well.

In that regard, I'll come back to Bob's question about audit, I think this is a very important aspect of pay for performance for these agencies, given the pattern we saw yesterday terms of the growth of new agencies. It's reminiscent of what was happening in the 1990s in terms of high concentrations of new agencies in certain areas and not
a real sense that these are necessary or whether they're taking advantage of the fact that we've got a high average margin and also the potential for even much higher margins. So if we have pay for performance, we need to be sure that the system has integrity in terms of the data that we're using to make rewards.

The last comment is about home health as a heterogeneous service. It relates in part to the issue of small agency but it also relates to the fact that this is not just a post-acute benefit. It's also a chronic condition management benefit that can go on for extended periods of time.

And when I look at the list of measures we have for home health performance, I feel like we've got a lot about recovery and rehabilitation and less about chronic care management. So if an agency is small and dealing more with chronic care management, then I think they are potentially disadvantaged by the system and I think we need to consider have we done enough in terms of the measures to capture that type of agency if people are specializing in that?

We're concerned in other areas about rewarding
things like coordination of services. That's something that's going on with home health, and I think we shouldn't create a system where we undervalue it compared to the post-acute kinds of services.

DR. CROSSON: I think what struck me about the presentation was the dichotomous relationship between the level of sophistication of the analysis and the graphs and the relative unsophistication or subjectivity of the measures that they're being applied to. So there's sort of non-parametric issue here.

And I just wonder whether, as you look through the things that could be measured, and maybe this is in line with what Nick was saying about pay for performance in general, would it be better to start off with a smaller set of measures that are as objective as possible? And some of them have some objectivity to them. Things like readmission, for example, and falls and things that pretty much have to be documented. And perhaps add to that some evaluation by the client or the family of the client. And start with something that is tight. And then later on, after you get some sense of what else could be measured, go beyond that.
But to me, trying to do a sophisticated statistical analysis and apply it to a set of measures that includes things that are, quite honestly, gameable, just doesn't seem to work.

MR. HACKBARTH: Sharon, any reaction to that?

MS. CHENG: I think one of the opportunities that we have with this report is to continue to comment on a home health quality measurement set. When we had an opportunity to talk about that several years ago now we suggested that in addition to the outcome set that we have, patient experience would be a good tool to add to it.

We spent a little time last year thinking about ways to measure the processes around fall prevention, patient education, wound care and other chronic activities. And so I think we'll have the opportunity here to discuss the measure set and to perhaps reiterate some of our ideas about ways we'd like to see this measure set evolve.

DR. REISCHAUER: I found this very interesting.

Do we know anything about the geographic distribution of agencies by quality?

MS. CHENG: That falls smack into our next steps.

We do have the real data and we've run the measures so far
on a national level and we've gotten the agency level observations. The next step is going to be attaching dollars to it, which we haven't done yet, and then looking at some of these agency characteristics and how they fall on our quality measure.

DR. REISCHAUER: Do we know anything about the distribution of performance, of the curve of performance from year to year? Because if it doesn't change much, and my guess it doesn't, I think there's a lot to be said by setting thresholds based on previous years parameters so people know what they're shooting for and what will obtain a reward and what will get them penalized.

And then, as you said, we're going to try to find out about using your standard errors, the relationship between quality and size of agency. Because the last thing you want to do is create an incentive to perpetuate a size that doesn't necessarily provide the highest quality care that's possible.

I sort of wonder, I guess along Jay's concerns, that the sophistication of the analysis here is maybe outrunning the underlying ability to measure what we want to measure. But that isn't what we were asked to do. You did
a great job.

MS. BEHROOZI: There's really a lot of interesting stuff to think about Sharon, thank you.

On the chart that begins on page eight you had referred to the little lines coming off the sides in your paper as whiskers, so I'll just refer to them as whiskers. I guess I'm concerned about the length of the whiskers in some of the cases. It seems to me, again picking up on what Jay said, that we really need to get to measures that we're comfortable enough with to shorten those whiskers because it seems like consistency itself should be something that we value.

And you referred in your paper to the fact that there are small agencies with consistent outcomes or more consistent outcomes than others. Well, then why shouldn't they all be, assuming that we have enough confidence in the risk adjustment and validity of the measures that we use to judge.

So I think you're right, Jay, that it really does all come down to that. But as I said, I would add consistency to the list of things we should be looking at.

Because as the beneficiary, of course, you want to know when
you go into an agency a little bit about how you're going to come out at the other end. Not just in terms of quality but that you can count on that quality.

And just to add and trot out my little red wagon that I talked a little bit about yesterday, and have in the past, I think some of the measures that might be worth looking at have to do with staff issues. Dr. Kramer's work in the SNF area that Kathryn referred to yesterday showed some evidence that there was a correlation between training of staff and outcomes. So those might be the kinds of things.

And there are certain levels of training required in certain states, I guess. Frankly, I don't know if Medicare has any requirements on that score. But if there are any those agencies that go beyond that, is there a correlate to outcomes?

And perhaps staff turnover, and I know that it's not so easy to get that data. But again if a lot of this is self-report, it might be a thing to add to the reports. And it's auditable. Those are facts that you can go back and check more easily than did someone's toileting ability improve at a point in time in the past.
So those are just some suggestions. I don't know if there are other areas, but again to stay with this notion of something being measurable and related to quality.

MR. HACKBARTH: Can I ask about that, Mitra? If there is a strong correlation between staff and outcome, why don't you pay for the outcome and then that will create the incentive to staff "appropriately?"

MS. BEHROOZI: Because you can measure the staffing issues. I'm trying to go to what these things are that are concrete. So if the outcome is stabilization of the ability to use the telephone, or whatever one of those things were on the list, as you said you can't go back and measure how much better the person was at using the telephone. But you can go back and say oh, last year their turnover rate was 45 percent and we have seen a correlation between stability of staff and better outcomes or that kind of thing. So it's really on the measurability.

MR. HACKBARTH: I see your logical chain. It gets circular if the study that verified the relationship between staff and outcome was based on subjective, unauditable outcome measures. But you could do, I guess, a special study where you established the relationship between staff
and objectively audited outcomes and then use staff for the big program where you don't have the ability to audit.

MS. BEHROOZI: I think that's true. I think that it would be useful to study it in more depth, to have some special studies looking at those things, especially if they haven't been the subject of other studies that you can refer to. I don't think that you can just go off the data that we have and just sort of reorganize the data that has its own flaws already.

DR. HOLTZ-EAKIN: I think this got asked but I guess one question I'm still not clear on is what exactly is an agency? You did something at the end, portraying it almost as a virtue, that I worried about in gaming this kind of system, which is aggregating and disaggregating your business in order to game the uncertainty and make sure that you cross the thresholds, particularly if you set them the year before and you know what you're aiming for. You take a couple of counties and break them apart when it's convenient to dump the losers, and pull them together.

To what extent is that possible? The unit of observation becomes very important when you start doing this.
DR. MILLER: There's a couple things there. I think when Sharon was laying out some of those ideas at the beginning, particularly the notion of people coming together. I can't remember whether you said it. I know internally we've talked about this. The notion would be you'd have to pick your partners and what you are before it goes in for the given year. But you're right, you could probably reform.

But I mean agencies -- and I'm way out here in your territory so be sure this is right. Agencies, you'd have to have a provider number, you have to have gone through the process of being accepted as a provider in Medicare. There's certain things you'd have to go through. Simply switching your agency, I think, is a little bit more complicated. But you're referring to changing your referral area or the area that you're covering. That's true and an agency could choose to change that at any point in time. And I suppose some of the question is whether they choose, even on a patient by patient basis, which is an issue that's come up in pay-for-performance more than once and not just here.

But the notion of just I was agency A and now I'm
agency B, there's a little bit more to that than just changing. And the notion would be that they would have had to have made this decision before the performance was measured, not in retrospect, in looking back and saying now I'm going to partner with you because you did a good job.

I hope that was all roughly correct, Sharon.

MS. CHENG: Absolutely right. Certainly, providers in home health are not facility base, so it would probably be easier to change the president of a home health agency than to change whether you are a hospital or not over the course of a year or two years. And to the extent that they would reorganize, I think we would probably have to settle on some kind of definition of the agency, probably at the level of a provider number that had been surveyed and certified as that provider and call that the agency.

The definition of an agency is the organization and the direct staff to provide at least one of the covered services. So what an agency is could vary quite a bit. One agency might have a small cadre of nurses. Another agency could have direct hires of nurses and aides and therapists and medical social workers.

I think one of the challenges here and one of the
things that we have a chance to elaborate, and is not unique
to home health, is the problem of what is the provider?
What are the associations among them? And what are the
challenges going to be for home health?

I think it speaks to the challenges in the
physician pay for performance, what do you do in a situation
where you've got a lot of small providers? And that's going
to be the opportunity in this report, to think about that.

MS. BURKE: It's really the issue that Doug
touched on that I was interested in, just to pursue it for
one additional moment, and sort of reference a part of Bob's
earlier comment.

That is, in addition to the geographic issue and
what we understand about this, is this issue of size. There
are a unique set of issues around home health. But I think
understanding -- because they can qualify as a provider, as
an agency, literally providing one thing.

I think it will be very helpful for us to
understand to what extent quality -- to the extent we feel
comfortable with the management -- to what extent that
really varies through the size issues and whether there is a
value in relooking at what, in fact, should we expect an
agency to be? What, from a minimum standpoint, should we expect ought to be provided, particularly to the extent that we are increasingly moving towards more collaborative and coordinated methods of delivery?

Literally, the sort of issue that you discuss when you talk about the small sample size and the strategies to address that suggest that they can sort of form these groups to come together so you can measure, or in some cases where you're looking at agencies have two patients or three patients. It becomes enormously complex to understand what quality means and how you control it in those settings.

So I think as we gather this information, as we can begin to understand what size means, what does a competent organization mean, what our expectations ought to be, it may help us move towards this how many things ought to be put together in order to provide a range of services that is appropriate and that we can count on.

I don't think we ought to go to the end of the world to try and figure how do you measure an agency that takes care of two patients. Maybe that's the wrong question, that is should we allow an agency that only provides care for two patients? I think this information
may begin to help us to understand that.

And I suspect it will be, in part, be geographic. You will see that there are tendencies in rural areas and the traditional places for obvious reasons. But I think we need to get a better understanding of that. It maybe you do, in this way, encourage people to begin to collaborate, to begin to partner with other institutions, whether it's with SNFs or with hospitals or whomever it might be or with other agencies.

But it's a little troubling. I don't want to create these systems that encourage organizations that we may, at the end of the day, figure out don't make a lot of sense for purposes of quality.

So understanding that quality as it goes across size, I think, will be helpful.

MS. CHENG: And this is an issue that I think is on the table. It's not directly implicated in the questions that Congress asked us but it is something that we as a Commission have thought about a little bit. And that is when we look at some with a very small agencies, because I was curious, too. How can you be a home care agency and I'm finding five, 10, 15 patients.
Many of the smallest agencies -- not all but many -- are Medicare and Medicaid. Now the way the system is set up now we do have information on their Medicaid patients, as well. They are required to conduct the OASIS on Medicare and Medicaid patients. And so for the purposes of measuring the quality of the agency one question we could consider or not would be are we measuring then the quality of their Medicare patients? Or are we measuring the quality of the agency, which could include Medicare and Medicaid patients? That would change our picture of the size of the agency but it would also implicate a question that may or may not complicate things.

DR. MILLER: I just wanted to say one thing as long as you were bringing this point up, and it actually can be connected to some other comments.

When we've talked about pay for performance, and we've run over a lot of this ground. How robust are the measures? Are we going to go about classifying people and looking at those kinds of things?

Also what is come up in those conversations once or twice is as you're moving forward, shouldn't you also be setting in almost floors, that as quality moves along you
say by the way, this should just be a condition of participation.

The way I interpreted your comments, which I think in some ways could start -- not on its own because there are other payment system issues -- but this issue of what is an agency and who should be in this game and who shouldn't.

It does drive us down that road to looking at some of this data and saying maybe the condition of participation here should be...

And so I just wanted to be sure that you understand that tool was in your arsenal.

MR. HACKBARTH: I think that Sheila has potentially presented a really radical idea, which is that being of a scale sufficient that we can reliably measure quality ought to be a basic requirement for all types of providers.

DR. REISCHAUER: But if you have private pay patients, Medicaid, and Medicare, what you care about when we're talking about size is the whole ball of wax. When we're talking about capacities and things like that, the presumption that because you have two Medicare patients doesn't now tell me anything.
MR. HACKBARTH: If Arnie were here he would make his regular appeal for sharing data, pooling data across different payers so that we can more reliably accurately assess quality for all parties, Medicare and private payers alike.

DR. SCANLON: The threshold is that you have to have served 10 patients period before you can become a Medicare agency. They don't have to be your patient load at this point in time. You just have to have served 10 patients. This is a vast increase in from what it used to be, which was one patient.

So this is the concern about the geographic pattern we saw yesterday in terms of growth. Why do we get more than 200 agencies in selected states, and you can't imagine them all starting off with a large volume that we might think of as the critical mass in order to be able to provide quality care.

MR. MULLER: I want to go back to Bill's initial point about a half hour or so ago. In an industry that has 17 percent margins for distribution between two and 27, there are such powerful incentives to work on your margin that are going to overwhelm any incentives for pay for
Because in provider sectors where the margins are minus two or plus two, pulling a 1 percent to 2 percent pool out for pay for performance has a real dramatic incentive effect. If you can get 27 by taking certain steps to control your population, et cetera, that's going to be much more powerful than a 1 or 2 percent pool.

So unless we're talking about 5 or 6 percent P4P pools here, which I don't think we are, I would say that the underlying incentives in this sector are to -- as evidenced showed yesterday -- are to grow in certain areas and under the PPS we move towards much more robust margins than we had in the prior period.

So I would say, whenever you can do 10 or 15 percent through effective management of whatever, that's going to overwhelm any effort towards P4P.

DR. REISCHAUER: Presumably this is a transitory situation because the Congress will turn to us for our recommendations for payment increases every year and after a few years we'll be down to normal margins.

MR. MULLER: So if we squeeze everybody down, then that's the right mix for P4P. I'm not sure that's the way
I'm just saying there's a couple of sectors which we saw yesterday in the updates where we have very powerful performance under PPS. And my guess is in those areas until you go to a different equilibrium you're going to have very low incentive except for certain agencies that have a certain scale, they're going to do it anyway as part of their mission to perform this kind of way and invest in those kind of systems.

So obviously, if you have thousands of patients and you have more computerized records, et cetera and so forth, one can go more in that kind of direction than one can if there are these smaller agencies and again where the margins overwhelm any P4P incentive.

MR. HACKBARTH: I think it's important point and one worthy of inclusion in our discussion, and it seems you can go one of three paths with it. You can say well, even with the large margins, go ahead with P4P. It won't make things worse. I don't know if that's true, but it's potentially one path.

A second path is to say you don't do P4P in places with high margins like this.
Or the third is you've got to rebase the rates concurrent with doing pay for performance.

I don't know which of those is the right answer but I think those are the logical possibilities.

MR. MULLER: I'm not arguing for the third. I think in light of some of the conversations we've had about where CMS puts their effort and in the sense that their staff is finite, like all staffs, and so forth, I would focus in areas that we've discussed not just in the last day or two but areas that we've discussed in the last year or two that are more ripe for the advancement of P4P than is my sense is here.

Again, it doesn't mean therefore I would vote to recommending a P4P effort here but I wouldn't make it the mainstay of where one begins. I think, as we've discussed, there's room in dialysis, et cetera and so forth, with the bundling and so forth composite rate where the advancement of a P4P effort perhaps could have a higher priority.

So again, it's not our role to necessarily suggest to the Secretary start in dialysis rather than in home health. I'm just saying for a practical matter it's more likely to have traction and buy-in in that area than it is
in this sector for the reasons I've suggested and Bill suggested in his initial comments.

MR. HACKBARTH: Although I think that there may be some other people who look at persistently high margins of this scale and say forget P4P, it's time to think about rebasing the rates.

DR. KANE: I just wondered if given how hard it is to look at home health on a stand-alone basis, are there big chunks of home health that would fall into some of the episode types that we are trying to develop measures for? And would that be a better way or maybe a more relevant way to get at the quality of home health?

I'm just thinking maybe there's stroke or something episode types that are very big that we think we can get our hands around that we can start thinking about episodic quality? Of course, it would have to be into a system that would be able to take accountable responsibility for it. But do we have a sense of how much home health might fall into an episode that would be a meaningful grouping for developing measures, like stroke or congestive heart failure?

MS. CHENG: We've got estimates of how many
hospitalizations by primary diagnosis are followed by home health, so we could start to look at that. And just about anybody who is -- everyone, by definition, who's getting home health has to have a plan of care signed off by a physician.

So all of this presumably is captured in a physician episode -- almost all of it would be captured in a physician episode someplace. And I would imagine it would be a lot of stroke or CHF or COPD episodes. I don't think home health would be a dominant form of care, though. If you looked at all Medicare beneficiaries with CHF, I'm not sure that the majority of them would be getting home health. But we could take a couple of slices at that.

DR. MILLER: We've built some data sets that you've seen pass through here to look at episodes that we've been doing over the last year or a year-and-a-half. We can present that information by condition, by type of service, how much hospitalization, how much physician, how much home health. So we can get at that number and pick out a couple of conditions that you might be focused on here like stroke and see if we can't answer it for you.

We have some quality indicators -- I'm talking
about just dollars now. The outcome indicators are a little bit tougher and not as developed at all, related to the specific episodes.

DR. KANE: That may be what you want though, in the sense of trying to figure out what's meaningful about home health, is to say in these types of episodes it looks like when there is -- home health has a major effect on the outcome of the episode and so that's where you want to put your emphasis rather than on everybody.

MR. HACKBARTH: Okay, thank you, Sharon.

Next is a presentation on bundling in the inpatient prospective system.

MS. MUTTI: Good morning.

Commissioners have expressed a need for fee-for-service payment reform that encourages greater efficiency. Specifically, commissioners have noted that payment policy should foster cooperation among physicians and between hospitals and physicians to promote the right care being delivered at the right time. It should hold a team of providers accountable for a common outcome such as longitudinal efficiency. And it should encourage providers to invest in care coordination.
Several aspects of our current fee-for-service system and current Medicare regulations are barriers to these goals, as we've noted before. While hospital and physicians can influence the volume mix and cost of one another's services, they are not currently rewarded for collaborating to appropriately constrain each other's service use. Instead, more admissions and use of outpatient services, increased income for hospitals, and more visits, procedures, and tests increase income for physicians.

Under PPS, hospitals are motivated to collaborate with physicians to restrain physician use of hospital resources. But they are prevented by gainsharing restrictions from financially rewarding physicians for reducing hospital costs associated with Medicare patients.

In addition, fee-for-service payment does not reward providers for longitudinal efficiency. That is the service use over an episode of care. As a result, most hospitals and hospital-based physicians have not invested in the coordination of care subsequent to discharge to prevent certain readmissions.

The combined result is that patient care is not coordinated, more care rather than appropriate care is
rewarded, and Medicare and beneficiaries pay more than they should.

This presentation offers two options to improve the incentives implicit in Medicare's payment policy and it focuses on care delivered right around the inpatient stay. The options are intended to be consistent with the goals I just discussed on the previous slide.

The first policy option is to bundle hospital and physician payment for inpatient care. The second option is to reduce payment for potentially avoidable readmissions. They could be pursued in tandem or independently of one another.

In the next slides, I'll discuss the motivation for these options and some of the information issues. I should just say right at the beginning, we have not thought through every aspect of these options. Our intent here is to give you enough of a sense of the idea to get your reactions and thoughts on how to focus our next steps of our research.

A number of factors motivate a policy option to pay a bundled amount to hospitals and physicians for the inpatient care. First is the variation in spending for
service use around hospital stays with no indication that
more spending results in higher quality across regions.
Elliott Fisher and his colleagues have found that the rate
of physician visits during hospitalization varies widely,
much more widely, in fact, than for outpatient office
visits. Rates for inpatient visits and specialist
consultations in high spending regions were more than twice
that of rates in lower spending regions. This suggests the
opportunity to appropriately restrain resource use.

Second is the experience under Medicare's
demonstration on coronary artery bypass graft surgeries that
was in the 1990s where certain hospitals received bundled
payment for the hospital and physician care during the
admission. With the bundled payment, the majority of
participants were able to successfully align incentives
among physicians and hospitals so that they reduced ICU,
nursing, pharmacy and lab costs as well as consulting
physician visits and post-acute care spending. No decrease
in quality was observed. In fact, mortality rates continued
to decline among these sites across the course of the
demonstration.

It could follow then that introducing a more
sweeping policy related to bundled payment could result in similar types of savings. Considering that Medicare spends about $7 billion annually for physician services during the admission, or about 12 percent of total physician spending, behavior change in this area could produce significant savings.

How could bundling work? To help illuminate the implementation issues, let me outline a possible approach. The payment could be set at the average amount, similar to how DRG payments were determined. Hospitals and physicians would need to form an organization that would receive the bundled payment and distribute it among themselves. The approach, therefore, permits gainsharing. That is the ability of physicians to share in the hospital savings they help produce.

Policymakers may consider applying these this policy to only a subset of conditions or discharges rather than across all inpatient stays. Particularly if the subset were selected on the basis of volume, spending, and the ability to improve, the policy could simultaneously be manageable for hospitals and physicians and also achieve some quick and tangible success for Medicare and its
beneficiaries. The availability of quality measures should also be a factor in selecting target conditions to help mitigate any incentive for stinting.

Perhaps one of the thorniest aspects of this policy option, however, concerns the ability of hospitals and physicians to come together to agree on how to share the payment and, in turn, whether to make the policy voluntary or mandatory. The first question, can hospitals and physicians constructively agree on an equitably way to share the payment? We've seen, in the New Jersey proposed demonstration on gainsharing a couple of years back that those hospitals and physicians were able to come together. In the CABG demonstration in the 1990s, those hospitals and physicians were also able to come together.

But we also know and we hear about physicians and hospitals tensely negotiating the allocation of current perks and payment for certain services such as ER coverage. We also know that hospitals and physicians in some markets are in competition with one another as physicians open their own hospitals and imaging centers, further adding to this discord.

So we wonder asking them to revisit all these
payment rules may make things worse. For this reason, a mandatory bundled payment may not be a realistic option for all communities, at least not in the short term.

So voluntary approach is an alternative but it is also tricky because those hospital's physicians most likely to financially benefit will volunteer for the bundled the payment. That's assuming that they can agree on the terms and get over the discord we talked about, which in turn costs Medicare. For this reason, there would need to be a payment penalty for those high-cost facilities and their physicians who opt not to participate. The next slide tries to illustrate this dynamic graphically.

This slide is only an illustration. It's just intended to clarify the incentives under a voluntary approach.

You can see on the left side of the slide a vertical line with ascending dollar values attached and $5,000 is bolded in the middle. These are hypothetical combined physician and hospital payments for inpatient care. The national average payment is $5,000, and in this hypothetical standard we're assuming that that's standardized so that it doesn't reflect adjustments for
wages, teaching, DSH, and outlier payments.

Some hospitals and physicians provide inpatient care for less than the $5,000 and some provide it for more than the $5,000. The difference is primarily attributable to the number of physician visits during a stay.

These numbers do not reflect the variation in hospital costs.

Those hospitals and physicians providing the care for less than $5,000 have a strong incentive to participate because they will get a higher bundled amount than the payment they current receive. To the extent these are the only providers that actually volunteer for the policy, we spend a lot more. As I said before, that's why you would need to design a penalty, perhaps a withhold on the fee-for-service payments to hospitals and physician services during inpatient stay in order to make it at least budget neutral.

So to recap the pros and cons of the bundling option of hospital and physician payments around an inpatient stay, the pro again is the potential to align incentives between hospitals and physicians to reduce not only the hospital costs but also unnecessary physician visits.
The cons or concerns here include the challenging implementation issues for Medicare and also for hospitals and physicians. On the Medicare side, exactly how would budget neutrality be ensured? Exactly how would the quality measures be used to prevent the stinting?

As I said, the second concern here is the potential adverse dynamics that could result when hospitals and physicians are negotiating. With each hospital potentially having a different payment rate for physicians, which would then could vary by specialty, we raise the possibility of unintended consequences in some markets. Would tension between specialties arise during the negotiation that might undermine their ability to collaborate on patient care? Would the policy intensify current competition for those physicians who bring in a high volume of high-margin services? And ultimately drive volume or give some hospitals an unfair competitive advantage? Those are just some of the questions that we have at the moment.

Some protections certainly could be designed to try and counterbalance those adverse possibilities, such as limiting the physician bonus payments or the differential in
bonus payments. And then, of course, if those were adopted they would also need to be monitored.

While bundling payment for care during the admission should encourage greater efficiency during the admission, it does not provide any incentive to hospitals and physicians to avoid unnecessary admissions. So this second policy option here is focused on adjusting payment to discourage a subset of unnecessary admissions and we call these potentially avoidable readmissions. As I mentioned earlier, it could be implemented in tandem with the bundling or on its own.

Studies have shown that patients are more likely to be readmitted if they had complications during the stay such as anesthesia complications, infection due to medical care and hemorrhage. Many of these can be avoided with reengineering care processes, as we actually heard from a panel earlier in our session here in September. Some have found that by identifying vulnerable patients and providing care coordination support prior and subsequent to discharge, readmissions were significantly reduced.

Medicare readmissions are significant. In our analysis across all non-ESRD beneficiaries who survive the
hospitalization, we found that 2.6 percent of admissions result in a readmission within three days, 5.8 percent result in a readmission within seven days, and 16.7 percent result in a readmission within 30 days.

These readmission rates appear to have slightly increased from 1991 and 1997, years for which we have performed a similar analysis. With inpatient Medicare spending over $100 billion in 2006, Medicare spent somewhere in the ballpark of $16 billion on those 30-day readmissions.

How could a readmission policy be implemented? First, because not all readmissions are avoidable, Medicare would need a rule for defining potentially avoidable readmissions. Some states and payers are using clinical logic that identifies these related readmissions. They pay pair this logic with a specified time period, 15, 30, even 90 days among those we've talked to, within which those potentially avoidable readmissions would be identified.

Others have looked at all readmissions within a narrow time frame. For example, under its program measuring hospital efficiency, the Leapfrog Group counts all readmissions within 14 days of discharge. It specifically acknowledges that -- and I'm quoting here -- "the
readmission window was reduced from 30 days post-discharge to 14 days in part to increase the likelihood that the readmission was related. Nevertheless, it is likely that some readmissions as counted are not related to the earlier discharge, but that will affect all reporting hospitals."

Another issue is how the payment penalty for potentially avoidable readmissions would be structured. One way might be to reduce payment for the initial admission, but if a related readmission was not detected at any hospital within a designated time period -- 10 or 30 days -- Medicare would pay the hospital the balance. If the readmission did occur, the hospital would not receive the balance for the initial hospitalization but would receive full payment for the readmission. This approach keeps the penalty on the hospital whose initial care led to the readmission, which may be a different hospital than the one that the readmission occurs at. There are several ways to structure this. We talk about another in the paper and we can go into that further in discussion.

The final design issue I'll mention on this is whether Medicare should keep all the savings or share some portion with providers as further incentive to avoid
readmissions and forgo that revenue associated with the readmission.

With that, I look forward to your discussion of these options and thoughts on further analysis.

MR. MULLER: I've been in favor of more bundling in comments in the past but just thinking through some of the prodigal difficulties here, if we go to slide six for example, looking at the national average payment. You start thinking about does that include DSH? Does that include IME? Does that include critical access?

So for example, how one brings it in. If you go back to some of the work we did on specialty hospital two years ago where we showed that there were major opportunities within a DRG to select patients and do very well with low severity patients and to have negative margins with high severity patients, in some ways how one constructs this payment, as you've noted, Anne, leaves room for a lot of people to come in to get in under that high average.

So for example, I think we said in the presentation yesterday that three-quarters or so of the hospitals get DSH payments, and I know of different magnitude. So how we bring all those special payment
factors in to this calculation, I think, is a very difficult thing to sort out.

In addition to that, some of the real savings are secured by management in the outpatient setting. I don't think you're suggesting here we combine inpatient and outpatient rates. This is largely just around the inpatient stay. But how then one brings outpatient payments and APCs into this, as well.

So I think this is one of the ones that I find intellectually very fascinating but when I start thinking through how one implements this given the variety of features we already have inside PPS, it is just quite daunting as to figure out how one, in fact, meets those kind of difficulties.

I was just wondering, just as an illustration, how would you put DSH, IME, and critical access into this?

DR. MILLER: I think that is -- at the outset of her presentation she said there were still issues that we were thinking of working through. And you've identified it, we're aware of it. You could go through a couple of different ways. I don't think at this point we would be able to go through an example with you.
MR. MULLER: I would say that 80 percent of hospitals would be either critical access, DSH or IME. I'm just guessing off the presentations the last few days. So they don't look at what they're getting right now as a --

DR. MILLER: Agreed, and there's a couple of ways you could think about how to deal with that, and some of them you would probably not particularly agree with. And so I do understand your point on the bundling. Internally we went through some of this and that's why we wanted to bring the idea up and see how far it got.

But one question I have for you is do you have any reactions to the readmission policy?

MR. MULLER: I think there's probably more that can be done there in a practical way. My quick reaction to it -- and not just today but having thought about this over the last couple of years -- is that it's a simpler -- on the basis of administrative simplicity -- not to say it's simple. But I think it's simpler than the set of issues around bundling.

I think one could think about how to implement that. In fact, some states, in their Medicaid program, have done such things. And the IHA now, there is some movement
on never events -- not to say readmissions fall in the never
events -- but I think increasingly people are looking at
that continuum from never events to reasonably predictable
readmissions that shouldn't occur as arenas in which one can
look for payment reduction that may be fairer than just
payment freezes and so forth.

I would look at -- as obviously I'm sure you have, Anne. I would look at some of the state efforts on Medicaid
on the readmissions side to see what kind of learnings might
be there.

MR. BERTKO: This is very intriguing and hopefully
has promise.

I want to offer a word of caution and perhaps a
direction for you. In the late 1990s this was put up in a
different form called contact capitation. I don't know if
you've talked to any of the people that have offered that.
One. Okay, good.

And then there are two consumer directed companies
that have tried that in the 2000s, in terms of pooling
bundles together.

The caution here is that contact capitation didn't
go anywhere as a general policy but it may have been too
ambitious at the time.

The second comment is somewhat related to this, but with this slide, slide six here, it strikes me at least as the payment penalty part of this might be very difficult to implement and I'd offer a different way to do it, which would be to think of it almost more in the center of excellence type of thing where there would be a benefit incentive for folks to head towards the hospital systems that accepted these. You might be able to structure that in a way that would do that.

And here's where the hybrid with the readmission penalty might be coming in so that it would be not only more efficient but also you'd have some quality measures associated with it. $100 off the $900-plus deductible could be a fairly strong incentive by itself.

MR. HACKBARTH: Could you go back for a second, John, and just say a bit more about contact capitation and specifically why it didn't go anywhere?

MR. BERTKO: Here's my recollection only. There were a couple of companies and consultants offering it. They would attempt not only say for something like CHF or some heart procedures, which would be very apt for putting
bundles together, but they tried to have contact capitation for -- I'll pick a wide number -- 2,000 different procedure or treatment mechanisms.

And the big ones, this comes back to what Nick was talking about, the focus on the big ones would be useful. But as a payment structure for a company say like ours or some other company dealing with 15,000 procedures, it was ineffective because it was much too complex.

In fact, the consumer directed companies -- there was one, in fact, that said here's a shopping cart. Pour in, as in the Amazon metaphor. Let's see, we'll buy any future CHF procedures from here, we'll buy appendectomies from there, we'll buy others from this group of doctors. It was unbelievably complex.

So I think a focus here on a somewhat small number of high-cost fairly common procedures might be useful. And my caution is to be careful not to say this will work for all 15,000 procedure treatment dyads.

DR. MILLER: Just to be clear, I think our sense, and I think Anne said this at the outset, but just to make sure case in the public or anyone else missed it, I think the idea is to focus and start with a few DRGs.
If I could just ask, can you say a little bit more about your second idea, the centers of excellence? And why it doesn't potentially run into the problem of saying to a group of good actors well, I'll share savings with you and then letting bad actors just continue to bill? And why that would be kind of a complicated -- do you see how the incentive --

MR. BERTKO: Yes. So this reflects upon our experience with Medicare Advantage folks and lining up here and saying aside from Ralph's worries that that $5,000 number there is a good number for the bundled payment there. But that the range, with $600, $400 for the less efficient ones is an appropriate amount. And you are paying $200 or $300 on average more to those that are efficient.

When you turn some -- and I'll use actuarial portion or sharing over to patients, they actually do a pretty good job of selecting for themselves for those focused amounts. And so you are, in effect, gainsharing with patients to direct them. And I'd almost guarantee that if it was bundled with quality and shown as such, that you would empty out the higher cost ones.

And again once you focus on those where, say in a
large urban area you have half a dozen hospitals competing
for hearts with a variety of cost and other implications.
People will vote with their pocketbooks if you provide that.

Now once again, the prevalence of Medigap and
other supplemental coverage is yet another confounding
factor and I was aware of that. But many of the large
employers, I think, would be highly supportive.

So now I can play Arnie. They'd be all for this,
except I should say it in 10 more minutes of talk.

[Laughter.]

DR. MILLER: Can we strike that from the record.

[Laughter.]

MR. BERTKO: Sorry, Arnie.

DR. WOLTER: I really think that we ought to
implement this as immediately as possible in Philadelphia.

[Laughter.]

DR. WOLTER: First of all, I'm very supportive of
this. I think focusing on some top number of DRGs by volume
and cost and whether that's three, for practical reasons of
the learning curve, or five or 10, I don't know. But I
think that would be the way to start.

I would favor being a little more bold in this
area. If we're going to be serious about the sustainability issues and all of the conversations we've had over the last few years, when are we going to push seriously a tactic which might create some significant savings and improved quality? This would be a great place to start. And what a major statement if we could do that.

In my view, if we could work out some of these details, and this worked with the DRG period, you could imagine extending it to a 60 or a 90 day bundle so that do bring in some of the outpatient pieces into it.

I think it allows the accountable care organizations to start to form. I would raise the issue that they might even be the organizations that receive the dollars, so that we could create an incentive for physicians to want to do this and maybe start to get away from some of the mistrust that exists in the physician hospital environment because of these concerns about hospitals being in control of everything, although many physicians might be quite happy to have the hospital be the recipient of the dollars.

It allows us to have a place where we're now putting measures in place more at a system and accountable
unit level, which gets us away from some of the issues we've talked about with measures at the individual physician level. It allows groups and integrated systems, as Jay and I have fostered and believed in, to play in this area. But it also allows IPAs and individual physicians to play, as well. So it's equitable in that sense.

I do believe it would be accompanied by robust measures of both cost and quality. That would be a critical area.

And you know, if it did that, we would be doing something here that has more value, in a way, than the burgeoning physician-owned facility situation or the burgeoning physician/hospital joint venture situation where we don't necessarily have as robust a set of quality and cost measures as we would be requiring here.

Back to another comment Jay made yesterday, I kind of like the idea of moving from the gainsharing term to something like shared accountability because we do want to be talking about quality as well as cost sharing.

You could see this moving beyond the DRG thing in years ahead, so that we could even include outpatient care down the road, chronic disease management, advanced medical
These units would benefit managed-care companies because they would know have accountable units to deal with, as opposed to panels of individual physicians.

John, ideally the private sector would want to play so that there was some uniformity in terms of how organizations dealt with this. There are strong links here to the hospital and physician pay for performance areas that we've been discussing in the last couple of days. And in fact, perhaps this is an area where that hospital 2 or 3 percent could sort of be linked in. And so I think that's a real positive.

There are strong links here to the conversation we had yesterday about alternatives to the SGR and that this is a strong movement into more value-based purchasing. It's also a strong signal about our longer-term belief that there needs to be a change in how health care is organized if we're really going to tackle the cost and quality issues that we face.

It's also, I think, a strong signal that we need to be more focused on the patient because right now so much of the conversation is about how to pay physicians for
performance in this silo, hospitals in performance for that silo. But really, if we want to follow the IOM principles of being patient-centered, we have to find ways to follow the patient across sites and over time. And this could be a starting place where we could learn how to do that.

I'm a little leery of the center of excellence term, I think, John, because my understanding in the past on gainsharing is that was used in a competitive way that allowed some in and some out and it led to lawsuits. And it was one of the reasons this thing didn't go anywhere else. So I would favor allowing anyone who wants to do this to play. Actually, I would favor having it be optional in year one and mandatory by year three or something like that. And how you would design the penalties, I don't know. But perhaps if you don't do this you're not eligible for the 2 percent quality incentive in the hospital world, or something like that, Ralph, so we don't have to worry about all of this DSH and IME stuff. I don't think the critical access hospitals are in this to start with anyway. This is the PPS thing, I think, to start with.

I can't read my last point, so I'll stop there.

MS. DePARLE: I couldn't agree with Nick more. I
think this is really exciting and really would move us in
the right direction.

I think it builds on what we learned from centers
of excellence. I think you're right, Nick, that one of the
reasons why that foundered was because some institutions
resented the notion that a particular institution or set of
institutions would get Medicare's seal of approval. So
perhaps it was politically premature.

I think this would allow us to build on the good
things that we learned from that demonstration for patients
and for the Medicare system and yet take it forward in a way
that perhaps gives it a little more chance of political
sustainability. So I like that.

I wouldn't want us, and I don't think you were
saying this, I wouldn't want us to get away from the notion
that at some point, though, that we might say that some are
in and some aren't, or some pass muster and some don't.

At some point I think, and maybe we'll be in some
happy situation where that wouldn't be the case, where
everyone is in Minnesota and is above average. But in the
system we're now dealing with, I think we do have that. And
at some point I think we have to be clear-eyed and willing
to say there are some differences here. But I'm willing to
start right here.

I'm interested, Anne, in following up a little bit
on the readmissions piece of this, as well, because I think
that's potentially very exciting for patients.

I didn't see numbers in here. Do you have any
estimates on what kind of savings Medicare could get from
avoiding readmissions? To say nothing of savings for
patients and just the impact on them.

MS. MUTTI: We just did the back of the envelope
estimate where we were thinking if there's about $100
billion on inpatient PPS spending and we were seeing
readmission rates of 16 percent. That's total readmissions.
That's not just potentially avoidable, so this would be like
the maximum, within 30 days, that 16 percent of the $100
billion.

I don't know exactly what percent of those are
potentially avoidable readmissions. That would be what we
would need to find out.

MS. DePARLE: It's still a rather large number.

MR. BERTKO: If I can just add to that, some of
our private fee-for-service would indicate that not only
readmissions, but there's an ER admit category, too. It could be reasonably in the 2 to 3 percent neighborhood.

MS. DEPARLE: That's avoidable admissions. I think you and I have talked. Initial admissions. Or are these readmissions?

MR. BERTKO: No, it's mostly in the readmission, extra ER, category in terms of what we're fighting. I think that comes up as a reasonable estimate of that 16 percent total that's in there. So it's a big number but not gigantic.

MS. DePARLE: And trying to be fair about it though, I was interested in the studies that you cited. And at least the one about the intensive nurse counseling, is that a Canadian study? It's David Naylor, I think, and he's a Canadian doctor, I think.

So that made me wonder how applicable it is, number one? And number two, how much would that bundle of intensive services cost? Is it almost like a home health benefit post-admission?

MS. MUTTI: I'm not sure that it's a Canadian study. I guess let me find out about that and get back to you.
DR. MILLER: I just want to reinforce the transaction that the three of you just had, so that nobody in the public, or specifically the press, walks away with a 16 percent savings number here.

The readmissions, depending on the days, readmissions could range from as low as 3 to as high as 16. And then within those two numbers, we have not defined the potentially avoidable admissions. So just to be clear, I didn't want anybody to go off and write an article and say there were 16 percent savings here.

DR. REISCHAUER: I think this is very interesting and I hope we forge ahead on this.

I was looking at this chart and thinking would you really set the payment level at the national average payments? Presumably it's the folks who are below that are providing high quality efficient care. And so the number you would hope they end up with -- maybe not in the first year -- is somewhat below that.

Then I'm wondering, if you're above this and this isn't mandatory, why would you participate? And if you were a hospital, I suppose you could participate and change the way you provide care and have hospitalists do this. So
you'd have a change in really the structure of physician employment within these markets.

Because I can't imagine how one could reach a compromise here in, let's say going to Elliott's work, the Los Angeles area where there's a steady flow of consulting physicians in some of these medical centers.

And how do you bring about a change in that situation unless you do it in a mandatory fashion? And then you would need some way of controlling the numbers. And the only way the hospital presumably would get this bundled payment and could do that would be to turn to its own staff.

MR. MULLER: The world doesn't work that way. For example, a lot of the admissions come from cardiologists on the staff and the hospitalists may take the patient that comes out of the ER and so forth, but they don't bring any patients into the hospital. You can't say cardiologists and gastroenterologists, go away -- if I understand what you're saying -- and we'll substitute hospitalists for you because they're a more efficient form of labor. It just doesn't work that way.

I think the challenge is, and we saw this in the CABG demonstrations seven or eight years ago, that they did
move it, in the chart here, below the $5,000 level and many
opted not to go in because basically the good performers, in
a sense, got economically penalized for being good
performers. And the lesser performers, as you indicated,
were better off staying out. So I think that's a critical
challenge.

In some ways, it almost forces you to go to
mandatory or have some other strong incentive. But again,
if you look at the range of numbers on that chart, $5,600,
so there's a 12 percent difference there. We're not talking
about any P4P numbers that are 12 percent.

So I think even P4P won't be sufficient to do
that, and John has indicated enough difficulties with the
centers of excellence because a lot of times, as we saw in
St. Louis, when United came in, they called a center of
excellence anybody that was at $4,400, with no quality
indicators.

So I think Nick made a very convincing argument as
to why we should go in this direction. I'm just saying that
we have enough experience with how these things come apart
by not looking at the numbers. I think it's very important,
therefore, to look at them so that the incentives are clear
to go in. And obviously mandatory, and I think if I got the import of some of Nick's comments, if you do it mandatory in some of the areas that are high cost like congestive heart failure, some of the respiratory diseases, that might be a way of looking at it. But I think on a voluntary basis you have all of the problems that you and other people have indicated.

Again, I don't want to therefore say mandatory is the way to go, but I think there is such a strong incentive for the lesser performers to stay out. And then you penalize the good performers. And then after a while they say why am I doing this.

DR. CROSSON: Can I make a point on this? I think Bob does raise the question that's going to have to come up at the end of this, which is who gets the bundled payment? Is it, in fact, the hospital? Because that shifts the locus of control that Ralph described. Is it the physicians? Or is it, as Nick implied, going to then bring about the need for the creation of entities to receive these payments that then can lead to perhaps other things?

DR. MILLER: We also had some of this conversation
internally, and I'm sure Anne can take you through it. But some of the thinking here was if you start on a voluntary basis, and there's 1,000 problems as we've noted, the notion would be that the person who steps up to the plate creates the legal entity that can accept the payment on behalf of both the medical staff and the hospital. The notion would be that that would be one way to blunt the concern on the part of the physicians to say but you're just handing the control to the hospital.

In some ways, that would have to reflect that they've actually come to an agreement enough to step forward and be able to make that.

Now in a mandatory world, you could mandate that that be the case. But we were thinking if this started voluntarily it might work that way, as one idea.

MS. BEHROOZI: Just a quick question and this is kind of following up on Ralph's point. When you look at the national average payment rate what all is that incorporating or ignoring? If you took a national average that would also smooth out the effect of the wage index adjustments for different areas, right? So I guess we would want to think about how to control for that, if that's true. I'm not sure
that that's true or not.

DR. MILLER: That's a technical question but you would just either adjust for the differences across the areas.

DR. REISCHAUER: Net all of these things and then at the end, when the payment was made, add them back in based on the characteristics of the hospital and the geographic location.

MS. BEHROOZI: The other question is about home health agencies and it goes back to Nancy's point earlier. In the paper it seems like you would contemplate that the influence on the home health agencies would be in the hospitals or physicians selection of agencies that would be good performers. But have you given consideration or should we now give consideration to trying to incorporate the home health agencies into this bundling mix? Especially if we're going to accept some variability, some whiskers, and some inconsistency in home health providers. Is this the time to incorporate that in?

DR. MILLER: I'll go ahead and take this because I have a feeling that at least I know some of the thoughts that are running through your head at the moment.
We specifically, on this presentation, targeted it and tailored it in a way because we talked about some of these ideas -- I'm going to say two or three or four meetings ago, somewhere in that range -- in which we talked about potentially larger episodes. There was a fairly heavy reaction like wait a minute, maybe that's not where we should start.

And so this specifically, Anne came to this discussion very cautiously with this is the inpatient admission only. You know, could think down the line if you wanted to get to that point.

But that's kind of the history. So she came specifically to talk about the inpatient admission. So that's not a big giant no, but the initial reaction when we talked about that was for more caution on the length of the episode.

DR. CASTELLANOS: In an ideal world without medical liabilities and costs, dollars divided, it's an interesting concept. I think, based on some of Nick's comments, really I think this is the direction this Commission is at least focusing in, especially with the SGR. I think we can incorporate a lot of these issues.
I would only suggest that some of this is being done already in clinical pathways in the hospital setting under certain DRGs, especially the high-volume high-cost DRGs. We have clinical pathways. We're not sharing with the hospital, we're helping the hospital. And we're aligning our incentive because we're working with the hospital, with the patient and trying to do the best quality.

My only real concern here is -- there's two concerns, one about the readmission policy. I think we look at the hospital, we look at the physician. But we're not looking at the patient. Patient compliance is a big issue there. A lot of patient compliance problems are causing these readmissions. I didn't see that brought up.

I'm not familiar with the Leapfrog study but the way I read it and I heard it this morning, any admission within 14 days is considered a problem of the physician or the hospital and I really not sure if that's correct. But again, I'm not familiar with that study. But that readmission policy really needs to be looked at very carefully.

I would only suggest that again, if you're going
to implement -- I think we need to down this direction but
we need to go down it carefully and we need to go down it
together. And I would certainly not make it an all-
embracing medical admissions. I would certainly limit it
very carefully, like they did with the CABG procedures,
looking specifically at the high-volume cost DRGs.

DR. KANE: I was reacting partly to the issue of
what's the difference between gainsharing and bundling, in
the sense that you can have some of the same inappropriate
incentives in bundling that you would have in gainsharing,
and that you would want to be sure that you had under
treatment and quality outcomes on anything that you tried to
bundle that were pretty good or you'd get the same backlash
that we got when we allowed large group practices to take
full premium risk and deny services to patients. So I think
there is that downside.

The gainsharing restriction are there for a reason
and you need to think about how to create measures that make
sure people are getting what they need to get.

I guess the other thing I was noticing or thinking
about is if it's only the DRG plus the physician component
that's bundled, then the only piece that's variable here is
the physician piece because the DRG is the same across the

country.  

The variability in your slide on page six here, most of that variability in payment is physician

variability. But yet there is probably -- so that may, depending on how well the hospital does, but that focuses on the physicians doing less or changing what they do, rather than necessarily changing some of the other parts of payment that vary.

And that argues to me that either the outpatient or the post-acute does need to be in here to really give them more payment -- the stuff that we pay variably for, we've only put the physician piece in there and not the post-acute and not the outpatient. But that's where some of the bigger variability and cost is to the program.

So I guess we're just limiting what we can benefit from if you're only doing inpatient. And I understand why we should go slow and not put it all in at once, but I think ultimately to get real savings you probably want to put more of the variable payment components into the group.

I understand why we can't do it yet, but I think that's really where the biggest improvement might be.
DR. MILLER: You're absolutely right in everything that you said. And you're also right in the sense that this is walk before you run. Some of that was based on the previous conversations. We are definitely open to going beyond this but sort of walking before we run.

To pull together Bob's point, depending on where you set, start setting the average for the total bundle, you can start putting pressure on the hospital side, as well. So you can think about a couple of ways that you could move down the road on this policy.

DR. KANE: That may be where they save the money actually inside, but I'm just saying where your payment variability is right now is not on the hospital payment.

MR. HACKBARTH: Okay, thank you, Anne. Good job.

MR. WINTER: Good morning. Dan and I are going to discuss ideas for expanding the unit of payment in the outpatient prospective payment system.

We want to first thank Sarah Friedman for her help on this project.

This chart shows that there has been strong growth
in spending for outpatient PPS services beginning in 2004. The line on the chart, which is sort of hard to see, it's the blue line, shows total spending which reached $26 billion in 2005. CMS projects that total spending will increase by nearly $9 billion by the end of 2008, to almost $35 billion.

The bars on the chart show annual percent change in spending per capital, was doubled from 5.5 percent in 2003 to over 11 percent in 2004.

As we will show later, much of the increase in spending from 2003 to 2004 was related to higher spending for drugs that received separate payments. If spending on separately paid drugs had stayed constant between 2003 and 2004, per capita growth during 2004 would have been much lower, by 6.5 percent, instead of over 11 percent.

CMS projects that annual per capita growth will be at least 10 percent from 2006 through 2008. This spending growth raises question about whether the outpatient PPS should be changed to encourage greater efficiency.

We are planning a broad long-term assessment of the design of the outpatient PPS. Today, we will focus on the concept of combining services provided during a single
outpatient visit into one unit of payment, which is called packaging. Issues we plan to examine in the future include bundling procedures and visits furnished over a period of time for a related condition into a single payment, whether there should be an expenditure target for outpatient services, whether to discount payments for multiple imaging services provided in the same session, and the method used by CMS to determine relative weights for outpatient services.

Over the next few months, we will focus on the issue of packaging. An example of packaging would be to create a single payment for a medical visit that includes ancillary services such as x-rays and lab tests. Another example would be to combine the cost of a drug with the drug injection into a single payment.

If an ancillary service or a drug is packaged, the cost is reflected in the payment for the primary service. For example, if an ancillary service is performed for half the patients who receive a given procedure, then about half of its cost would be added to the payment rate for the procedure. If the ancillary is provided by itself without a procedure or a medical visit, then it would be paid
Currently, Medicare's outpatient payment system has minimal packaging. Certain items are packaged with surgical procedures such as anesthesia, medical and surgical supplies, and implants. However diagnostic tests, such as x-rays and lab tests, are always paid separately. This creates an incentive to use more diagnostic tests.

In addition, Medicare pays separately for many drugs that are used with procedures and visits. To main categories of drugs receive separate payments. The first category includes drugs that exceed a certain cost threshold or meet certain other criteria, and these are called separately paid drugs.

The second category includes drugs that receive transitional pass-through payments for new technologies. This is different from the first category because pass-through payments are limited for a period of two or three years.

Other drugs are packaged, which means their costs are reflected in the payment rates of their associated procedures.

Hospitals may have a financial incentive to
substitute a high-cost drug that is paid separately for a low-cost drug that is packaged, as long as the separately paid drug is profitable. In the next few slides, we'll examine how this incentive might influence spending growth.

This chart shows spending for separately paid drugs under the outpatient payment system, which includes drugs that received transitional pass-through payments. In 2003, about 400 drugs were packaged with their associated procedures and 20 drugs were paid separately. The MMA mandated that CMS pay separately for more drugs beginning in 2004. Consequently, spending for this group of drugs increased by about 80 percent, from $1.3 billion to $2.4 billion.

Now we'll examine what happened to a subset of drugs that were subject to these changes. We identified 42 drugs that were paid separately as pass-through drugs in 2002. These drugs were packaged in 2003, which meant they no longer received separate payment, and their volume dipped by 4 percent in that year. In 2004 they were again paid separately and their volume grew rapidly, by 20 percent.

It's plausible that the sudden volume growth of these drugs in 2004 after a slight decline in 2003 was at
least partially related to their being paid separately in 2004.

Expanding the unit of payment to include more drugs and ancillary services has advantages but also raises some concerns. First, greater packaging should encourage hospitals to provide care more efficiently. For example, hospitals might use fewer ancillary services or fewer drugs that are paid separately. Hospitals that use fewer resources to provide a packaged service would be rewarded because they would keep the savings.

Also, these efficiency gains would help control growth of outpatient spending, beneficiary cost-sharing, and premiums. One concern about greater packaging is that it may lead to hospitals being underpaid for costly patients. Payment rates for a package of services should, on average, cover the cost of the entire package. However, some hospitals may treat patients who require more ancillary services or more costly drugs than average and these hospitals may feel pressure to avoid sicker patients or to sting on care because the payment rate would not cover these patients' additional costs.

However, an outlier policy could limit hospitals'
financial risk. The outpatient payment system currently has an outlier policy that provides additional payments for very costly services.

The second main concern is that greater packaging would create incentives to unbundle the packaged items. For example, if a diagnostic test is packaged in the outpatient PPS but paid separately in physician offices, the hospital might send patients to a physician's office for the test. Hospitals might also make patients come back for their tests on a later date so they could get separate payment for it. This behavior would inconvenience patients and increase their cost-sharing.

There is another outpatient payment system called ambulatory patient groups, or APGs, that does more extensive packaging than the Medicare system. APGs were developed by 3M as a precursor to Medicare's current outpatient payment system. APGs package low-cost frequently used items with their associated procedures and medical visits. Examples of the items they package are on the slide, including things like drugs except for chemotherapy drugs, basic x-rays, simple lab tests, and some diagnostic tests.

Although Medicare does not use APGs, some payers
do use the system, including Iowa Medicaid and Blue-Cross of Washington and Alaska.

We plan to learn more about the APG approach to packaging as we work on this issue.

Now we'll turn to Dan to discuss how we've begun to identify items that could be packaged.

DR. ZABINSKI: Our first step in identifying which items could be packaged in the outpatient PPS, we started by answering the following question: should we package all drugs and ancillary services with their associated procedures? Our answer to that question is no because packaging will sometimes result in substantial increases in the financial risk faced by hospitals. That is, the likelihood of experiencing a large loss from providing a particular service.

So we went on and identified two criteria that should be used to determine if packaging a drug or ancillary will increase the financial risk of providing a particular service. The first of these criteria is is a drug or ancillary costly in relation to the associated service? The first column in this diagram shows that if a drug or ancillary has a low relative cost -- that is the cost of the
drug as a percent of its associated service -- it could be packaged. An example is a pathology exam related to a costly biopsy.

Packaging a drug or ancillary with relatively low cost will have very little effect on the cost for providing the service, so there would be little effect on the financial risk facing hospitals.

However, if a drug or ancillary has a high relative cost, such as the cost of a chemotherapy drug relative to the cost of its infusion, we turn to a second criteria: is the drug or ancillary frequently used with the associated service?

Well, if a drug or ancillary with a high relative cost is usually used with a service, the box on the very upper right indicates that it could be packaged without a significant increase in the financial risk because most or all of the cost of the item would be reflected in the payment rate for the service.

However, if a drug or ancillary with a high relative cost is infrequently used with an associated service, such as replacing a catheter in a non-chemo infusion therapy, it could substantially increase hospitals'
financial risk. This could occur because only a fraction of the cost of the drug or ancillary would be reflected in the payment rate for the service. So in a small percentage of the situations where a hospital does use the drug or ancillary with that service, the hospital would bear the full cost of providing the service, creating situations where the payment rate would be well below the cost. Consequently, we should not package in these situations, as indicated in the lower right-hand box of this diagram.

So the take away point from the previous slide is as we consider which drugs or ancillaries to package, key issue is limiting increases in hospitals' exposure to financial risk. That is we do want to increase hospitals' financial risk but we don't want to increase it by too much.

So to limit increases in hospitals' financial risk, we need to establish two thresholds. The first is how constantly can a drug or ancillary be in relation to its associated services? And secondly, if a drug or ancillary is relatively costly, how frequently is it used with its associated services?

Setting these thresholds is somewhat arbitrary, and in our future work we will explore the appropriate
officials to set. To help in our exploration, we will consult with the developers of the APGs that Ariel discussed earlier, because they used relative costs and frequency of use to identify their packaged items.

Once we identify which drugs and ancillaries should be packaged, we asked the question should a drug or ancillary be packaged with all associated services or should it be packaged with some and separately paid from others? Well, if a drug or ancillary is packaged with some associated services and paid separately from others, some problems could arise. For example, hospitals may face complexities in explaining to their staffs which items are packaged and in which situations they should be packaged.

Secondly, opportunities for hospitals to unpackage could exist. Suppose, for example, an ancillary is using two similar services and is packaged with one but paid separately from the other. Hospitals may then have an incentive to use the service with less packaging even in situations where the service with more packaging is the more appropriate thing to do.

So the concept of what's called uniform packaging may be preferable. This option considers the cost and
frequency of a drug or ancillary relative to all associated services. Based on its relative cost and frequency of use, a drug or ancillary is either always packaged or always paid separately. For example, a drug that has a low relative cost to its associated services or is frequently used with most or all associated services would be packaged with all of them. So uniform packaging is preferable because it avoids or reduces the problems I discussed at the beginning of this slide.

Then as a first step in identifying possibilities for packaging drugs that are currently not packaged in the outpatient PPS, we analyzed the cost of separately paid drugs relative to the cost of their associated services. The first column in this diagram lists the categories of the relative cost of drugs. That is, what is the cost of a drug as a percent of its associated services?

In the second column, we show the percentage of drugs that fit in the categories in the first column. Then the third column shows the fraction of spending on separately paid drugs that fit into each category in the first column.

For example, the highlighted role includes the
separately paid drugs that have a relative cost that is less than 50 percent of their associated services. This row indicates that about 70 percent of drugs have a relative cost below 50 percent and these drugs encompass about 6 percent of spending on separately paid drugs.

Based on the criteria of relative costs, this table may appear to indicate that opportunities for packaging separately paid drugs may be fairly limited. However, this table does not fully reflect all opportunities for packaging drugs because it does not consider how frequently relatively costly drugs are used with their associated services.

In the future, Ariel and I intend to examine how frequently relatively costly drugs are used with associated services, which will expand the apparent opportunities for packaging.

On this diagram, we repeat the previous diagram, except we analyze the relative costs of separately paid ancillaries rather than separately paid drugs. An example of an ancillary is a chest x-ray or a pathology exam related to a biopsy.

Based on the criteria of relative costs, this
table suggests that opportunities for packaging ancillaries are greater than for packaging drugs, but opportunities may still seem a bit limited for ancillaries.

For example, 35 percent of ancillaries have a cost that is less than 50 percent of the cost of the associated service. These items encompass about 26 percent of the spending on separately paid ancillaries.

Once again, however, we still need to examine how frequently ancillaries with relatively high costs are used with their associated services. This will again expand the opportunities for packaging.

In addition, many of the ancillaries with high relative costs have low absolute costs. For example, we found that 25 percent of the ancillaries that have relative costs above 50 percent cost less than $50 in absolute terms. These ancillaries encompass about 46 percent of all spending on all ancillaries. What's happening in these cases is that an ancillary with a low absolute cost is used in conjunction with a service that has a low absolute cost. For example, many chest x-rays occur during a basic medical visit. That doesn't cost very much. In these cases, we think packaging the ancillary would be reasonable because it would not
present a great financial risk to hospitals.

A summary of our results and our next steps include the following: we found that some separately paid drugs and ancillaries are relatively inexpensive, so some opportunities clearly exist for more packaging in the outpatient PPS. However, most spending on drugs and ancillaries is for relatively costly items. So we'll examine how frequently these relatively costly items are used with their associated services to determine if they can be packaged.

Also, we need to identify thresholds for determining whether a drug or ancillary can be packaged on the basis of its relative cost or frequency of use with associated services. We plan to consult with developers of the APGs, as well as payers and hospitals that use the APGs to help guide our decisions as well as getting information on implementation issues and impacts on hospital spending.

And finally, 3M Health Information Systems, the developer of the APG system, is coming out with a new version of the APGs in the near future. We plan to learn about this new version and determine whether the APG approach can be adapted for Medicare and to use it to
estimate the potential impacts on hospital groups.

That concludes our discussion and we turn it over to the Commission now.

MR. HACKBARTH: Questions?

DR. CROSSON: I have a couple of questions on the thinking on slide nine. My intuition might take me to a little bit different place, but I want to see if we're thinking the same way. If the point of the packaging is to try to improve the frequency of usage of pharmaceuticals or ancillaries or make the usage as close to the appropriate usage as science would dictate, and also save enough money to make the whole thing worthwhile doing, if we look at this 4x4 table, the left-hand column where the cost of the drug or ancillary is quite low relative to the service, I agree that doesn't seem to be the target area. I suppose in relative terms if the service is massively expensive the ancillary could still be low and yet there might be absolute dollars savings. But that's not what the other charts tend to suggest.

On the right-hand side, where the use or the frequency of use of the drug or the ancillary service is high, that could mean that there is a lot of inappropriate
usage. It could also mean that this ancillary or this drug pretty much has to be used and science would dictate that it should be used most of the time.

The bottom column on the right, where it says that the use is low and therefore we should not package, to me is actually, I think, the area where there's the most likelihood of benefit because I would probably label those differently as the top right-hand column being nondiscretionary use.

Again, I'm going back to what the science of medicine would dictate. And the bottom right-hand one would be the discretionary use of a drug or a procedure.

And that's really the area where you do want to have the packaging; right? Because that's where the -- now you have to then balance the risk to the hospital against the utility of packaging and that's volume related. So that if, in fact, that particular ancillary was extremely high and only occurred rarely and the hospital was only dealing with this diagnosis rarely, then the times that they got paid the extra 10 percent or 2 percent or 5 percent in the bundled payments, might not make up for the experience if they had a bad year and they had three or four or five of
these patients. So there's a volume relationship.

But if you said we're not going to package in that lower right-hand column, then I think you walk away from the very point of the bundling.

MR. HACKBARTH: It all depends on what the reason is for low frequency of use. Is it because there are clear clinical guidelines and providers don't adhere to them? Or is it because there aren't clear guidelines and it's appropriate for some patients and not for others?

DR. CROSSON: And I'd argue that that is the situation most of the time.

MR. HACKBARTH: The latter.

DR. CROSSON: The latter is the situation most of the time. And that's where the inappropriate spending occurs in areas where there's a lot of clinical discretion because perhaps the science is not clear or perhaps there are economic incentives to use the drug, as was pointed out before, or to use the ancillary. So I'm not sure that I agree with the way this is formulated.

DR. REISCHAUER: I was just going to point out what you did, which is that bottom box under the separately billable is an environment in which you have an incentive to
overutilize. And if you package it you have an incentive to
underutilize.

DR. CROSSON: But doesn't this get to the point of
packaging?

DR. REISCHAUER: Why is it being used? Which is
what you raised. Is it the top right-hand box because it's
clinically appropriate all of the time? The answer could be
yes. Or because the incentive is so powerful to overuse it
that it's used all of the time.

DR. CROSSON: So the difference really is, at
least to me the difference is when are you dealing with
nondiscretionary ancillaries or drugs? In which case, the
packaging doesn't make a lot of sense. I mean, you get into
other issues about volume purchasing and things like that.
But the area where you want to use the packaging is where
the cost is high and the use is discretionary.

MR. HACKBARTH: Right. You want to make sure that
you're talking about variations in practice for clinically
similar patients and not variations in practice that are due
to dissimilar patients.

DR. CROSSON: Correct.

MR. HACKBARTH: Why is there the variation? Is it
because of inefficiency and then failure to adhere to
guidelines? Or different patients with different needs? If
you're bundling things together, and it's different patients
with different needs, then you're imposing a risk on
providers that may not be within their control or
appropriate for them to change.

If there is variation among treatment of
clinically similar patients, that's the sort of behavior you
want to get at.

DR. KANE: My first reaction when I read this was
this is the kind of bundling that kind of makes you feel
like you're practicing medicine, as opposed to setting some
kind of target that at our level we can set.

I guess part of this chart that shows the minus
four and then the bundled and the unbundled might be an
eexample of why I'd be concerned. How do you keep up with
the change in practice?

This is at a level where the drug, the ancillary,
the lab, and the newness and the turnover of practice or
change in practice might be constant.

So how would you keep up with what should be
packaged and what shouldn't be packaged, as well as the
issues that Jay raised? I just felt this was almost too close to actually telling people how to practice medicine, as opposed to a higher target that's a little more stable and long term in terms of a bundle.

DR. MILLER: My point was back on Jay's point, at the risk of being extremely confused about it.

In the lower right-hand corner, you took it from a clinical perspective and let me just take it from a payment perspective. I think the concern there -- and you guys might want to make sure this is all correct -- I think the concern there is that if something is very expensive and occurs very infrequently -- oh, and by the way, in an unbundled world if that situation is true you do have this incentive right now to bill for it. The data into that lower right-hand corner, in a real-world example, is if it's not happening frequently, they're not acting on that incentive for some reason which might suggest that the clinical concerns intervene.

But just put all that aside for a second. The basic payment concern is if something happens only a little bit of time but costs a lot of money and you build a little tiny average into every bundle, then the times when this has
to happen you're really underpaying the provider and
disincenting the situation when presumably it needs to
occur. And in this world where you can make money off of
each time you've provided it, they hadn't been doing it.

So we were taking that as sort of prima facie
evidence of maybe this is a place where you have to move
carefully.

Now we can rethink this and none of this is a no
to your point, but that was what drove us in that corner to
say you want to be careful here because you would be most
frequently underpaying, is what I'm trying to say.

DR. CROSSON: And the difference, I think, between
what we're saying is sort of the interpretation of what high
is or low is in this context.

DR. MILLER: To these guys' point, that's kind of
an arbitrary boundary. In the examples that they showed
you, they just picked 50 percent to give you a sense, and
that's very much going to be a complicated decision.

Because there's nothing that's going to tell you the right
number is 51 and not 52. And then I think that gets right
back to your clinical conversation that you're having.

MR. MULLER: Ariel, can we go to the chart that
shows the distribution of payments? Could you do it on the ancillaries please, rather than the drugs? Thank you.

I think for the ones we discussed very much in the last years is the doctor's visit in an outpatient setting with the MRI, CT and so forth, where there's been big growth. And I would assume that's one of the areas in which the ancillary is 200 or 300 percent of the procedure. I think the chart on the right, there's big bucks there.

So if there are other ways in which to look at that ancillary utilization; e.g., the kind of guidelines that we discussed on imaging a few years ago or guidelines one may have on diagnostic testing, though my guess is until you get to the new biologics and so forth or the proteomics, you're probably not in that 100 or 200 percent range.

There may be other ways of getting at this rather than the packaging but I think the packaging has the concerns that both Mark and Nancy spoke to, which is that you may be dramatically underpaying for something that's needed here and there.

So if we have concerns -- I'm assuming our concern is in the bottom of this chart. Am I fair to say that? Or is that inaccurate? The ones where it's 200 or 300 percent
of the cost of the associated procedure.

DR. ZABINSKI: That's where we get concerned about whether the drug or ancillary is used a lot with the associated service, when we got up to that range.

MR. MULLER: My question is just whether bundling or packaging -- using the packing word here -- is the right way to go about that or whether there are other ways of looking at that such as we have in terms of guidelines, critical pathways, and so on.

MR. WINTER: Part of our broad term plan is to look at some other tools that might help address use of expensive imaging like whether there should be a discount for multiple imaging services done in the same session, which is currently our policy on the physician side and was proposed by CMS for the outpatient side, but they withdrew it and are studying it further. So that's something we could look at to address that issue specifically.

Another area we might want to look at is looking at relative weights. There might be some distortions that influence volume growth.

MR. MULLER: My sense is just this is one where we need a little bit more, I think even with some of the
concerns that I and other people expressed about the
bundling on the outpatient side. I think we've thought a
lot more about that in a variety of ways over the last few
years. I think we need to have a better sense of what
exactly we're talking about here in terms of clinical
procedures and so forth and what we're trying to really get
it.

If it's imaging, which clearly could fall into the
bottom left of this chart fairly often, and diagnostic
testing is getting a lot more expensive, the imaging or
diagnostic tests coming in the next few years is not going
to be the simple basic lab cycles that doctors run in their
offices. And therefore, they would fall in the top of this
chart.

Maybe the work you're getting from 3M might give
you a little more clinical detail as to what exactly we're
talking about here in terms of procedures. But I think this
is one where having a little bit more clinical detail would
be at least quite helpful to my thinking and perhaps others.

For example, surgery doesn't fall into these
categories; right? That's the procedure. So what you would
put with the surgery would be the imaging. I'm trying to
figure what's the procedure and what's the associated ancillary.

DR. ZABINSKI: Something like if you do a biopsy, that would be a procedure. And the pathology exam related to the biopsy would be the ancillary.

MR. MULLER: That's where there's a lot of sophistication coming in that's going to put more in the 100 to 200 to 300 percent level in terms of the ancillary associated with the procedures.

So I think we just need to get a little better handle on exactly what kinds of things fall into this.

DR. MILLER: On that point, not necessarily the clinical guidelines point -- and I don't want to put you on the spot -- but we also had some conversation when we were talking about this internally about what could, at the upper end, be captured in bundling. Didn't we have something --

DR. ZABINSKI: One thing we found up here --

DR. MILLER: I feel like it's related to what he said.

DR. ZABINSKI: One thing that we talked about, Mark, is that a lot of the things up above the 100 percent mark were actually pretty cheap ancillaries that are
associated with pretty cheap procedures. As I said, particular chest x-rays, they're all following up above 100 percent because they're used with other very cheap procedures like medical visits. They only cost $40 each to do because they're also used with things that cost $50.

MR. WINTER: The other point that Mark might have been trying to get at is that these are often the ancillary services that are below 50 percent in terms of relative cost or below $50 in terms of their absolute cost, while they're fairly low cost, they are high volume. So if you add them all up it accounts for $900 million, according to our rough estimate, $900 million out of about $26 billion total spending on the outpatient payment system.

And that's not including clinical lab tests that are paid under the clinical lab fee scheduled but are provided in the outpatient department. And that's $2.5 billion. We're not suggesting by any means that all of those should be packaged or it's appropriate to package all of them. But if you were to include them in your thinking about packaging, you can start thinking about bigger dollars.

DR. KANE: But to get savings out of that package,
wouldn't you have to make some assumptions about how often
they should be provided so you're not just paying every time
they have a visit they're getting a chest x-ray? You have
to have some idea of what percentage of time they should be.
And that's where I'm getting nervous. I don't feel we have that kind of -- I don't think data can tell you
that at the patient level or the hospital level.

MR. WINTER: Maybe if we explained a bit about how packaging currently works, because CMS does some packaging
now in the outpatient PPS. It's based on sort of historical
patterns of use. So if they're packaging, let's say a surgical implant, and it's used roughly a quarter of the
time with a given procedure, then the cost of that procedure reflects about a quarter of the cost of the implant.
So it's a mechanical exercise rather than clinical saying it should be used half of the time or 75 percent of the time.

MS. DePARLE: I have one really basic question and a couple of comments, I guess. What data did you use -- maybe this was in the paper but I don't remember it -- to determine the cost of ancillaries and the cost of drugs?

DR. ZABINSKI: The cost of ancillaries came from -
the payment rates for these things are supposed to reflect the cost.

MS. DePARLE: But isn't that the charge, really?

DR. ZABINSKI: No, they take charges and adjust them to cost using cost-to-charge ratios. There's some question about how accurate that really reflects cost.

MS. DePARLE: That's based on the current outpatient prospective payment system, which was based on the historic charges for outpatient procedures; right?

DR. ZABINSKI: They use more recent data. Every year they come up with new rates they use a new year's worth of data to do it. Basically, the charge date is two years older than the payment rate. In other words, for 2007 rates they used 2005 charge data.

MS. DePARLE: I guess I'm just getting at, as I recall when the outpatient prospective payment system was put into place, the basic building block of it for the base payment was historical charges, not some scientific determination of how much does it really cost a hospital to provide an image? For example, with imaging, the hospital has already acquired the imaging equipment. I don't know whether that was accounted for on the inpatient side or the
outpatient side. There's a lot of questions around that data.

So I'm all for more bundling here, but I guess I'm just curious as to how we know we're getting at the right unit of payment or cost.

And the same thing for drugs. How did you guys come up with -- is that based on ASP? Or what is the drug data? Is that similarly, just what the hospitals are saying they pay?

MR. WINTER: For 2004, we took the actual rate for the separately paid drug. And that varied by type of separately paid drugs. So pass-through drugs were based on a percent of AWP, either 85 or 95 percent. Many drugs in that sort of separately paid category, the non-pass-through separately paid drugs, many of them were based on a percentage of AWP, as well. Some were paid on charges reduced to costs. And then over time they transitioned now so they're all ASP plus 6 percent. But 2004 was a very messy year. We're going to plan to extend this analysis -- perhaps not the detail type we're looking at now, but in terms of total spending for separately paid pay drugs, we'll extend that to 2005. And so we might be able to see some of
the effect of that transition.
We won't get to the endpoint of the transition
this year because that's data from 2006 and we won't have
that until next year.

MS. DePARLE: So if you had AWP data, presumably
those numbers will be much higher than what we would end up
with ASP, if our experience in other areas is the same. Are
we now moving to ASP for everything on the outpatient side?

DR. ZABINSKI: Yes, it's pretty much across-the-
board.

MS. DePARLE: That's the good news. Believe me, I
don't want to discourage this work because I think it's
important and I think it's the right direction to go in. It
just reminds me of how complicated this was and, in fact,
your bringing up the APGs reminds me of the process we went
through when we were implementing this -- and Mark will
remember this, as well. I don't remember the exact numbers
but let's say there were a lot of concerns about whether the
OPPS would be granular enough.

In fact, all of the emphasis from the industry at
least and from Congress was don't harm anyone, don't harm
any hospitals.
So we threw out a proposed rule that was 300 or so APCs. And it came back, and our final rule was 500 or something, and it's only gone up from there, I think.

So again, that was 10 years ago. Everything is better now, maybe. Maybe everyone would be in a different place about this is the right direction to go. But just as a cautionary tale, there was an awful lot of concern around some the things that Nancy is raising, but also just every -- I mean how many hours did we spend in meetings with individual companies about making sure that there was enough in the APC to cover their whatever it was, drug, device or whatever? It didn't lend itself to this kind of treatment at that point.

And then finally just a comment, to follow up on what Ralph said. Whatever we do here, I think it's really important that we look at the incentives that we might create for this to shift over to physician offices. I think we've talked about that in a number of different settings over the last two days, and frankly over the last two years.

But I do think we could solve one problem and create another one, and we shouldn't do that. We shouldn't create more incentives to shift all of this out into a
different setting.

MR. WINTER: If I could just make a quick point about this, the chart we showed you about the relative cost of drugs. This was done using 2004 data, where most of the drugs in this chart were paid on an AWP basis. But if we did it for 2006, I suspect you'd see a lot more drugs below 50 percent relative costs because the costs are lower and the procedure costs probably went up since then.

MR. HACKBARTH: We've got to finish for today.

Thank you, Ariel and Dan.

We'll now have a brief public comment period for the next 10 minutes.

MS. McILRATH: You're probably surprised that I'm here today instead of yesterday.

I just wanted to make one clarification because I think it's something that has been confused in the discussion on the Hill. On the update for the physicians, the recommendation said that it's input price increases minus productivity. There was some discussion this morning that was referring to the MEI minus productivity. And to just clarify that the MEI already has the productivity taken out of it. So it is the written recommendation, as opposed
to the MEI minus productivity.

MR. MAY: Hi, Don May with the American Hospital Association.

I really enjoyed the discussions today on the inpatient and the outpatient bundling or packaging.

Just a couple of thoughts on the outpatient system. In the work that we do with all the different payment systems, I believe the outpatient is the most complicated PPS we work with. And I think it's partly because it is a combination of historical fee schedules like physician services, but also historical bundles that we're used to from the inpatient side.

It's made it very difficult to analyze whether something should be packaged or not packaged. And I would just maybe suggest we look at, as we talk about packaging, it's going to be very difficult to look at clinic visits, some of those low-level visits, and think about how to package because a lot of the services that could generate it are based on the complexity in diagnosing the patient, maybe the severity of the patient. And a lot of those tests are going to be driven by that complexity.

Where there may be more opportunity for packaging
is maybe in some of those historical procedures that have been down on the inpatient side and now have moved to the outpatient side. So we've historically paid for them in a bundle and now we've got two or three different procedures that are in different APCs that we're paying for.

We may be able to think about this in a way where we start to look at packaging from a procedure base where it was done on an inpatient side, where you're really talking about a bundle of services, where it's very different than a clinic visit or an ED visit that has lots of different ancillaries together.

I would just encourage the staff to take a look at those ideas.

MR. HACKBARTH: Okay, we're adjourned. See you next time.

[Whereupon, at 11:42 a.m., the meeting was adjourned.]