MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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Thursday, March 18, 1999
10:30 a.m.

COMMISSIONERS PRESENT:

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JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
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PETER KEMPER, Ph.D.
JUDITH R. LAVE, Ph.D.
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AGENDA

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P R O C E E D I N G S

DR. WILENSKY: We are, unfortunately, starting around 45 minutes late. We will just have to see how the time goes during the day and it may end up pushing everything behind some if we can't catch up during the sessions that are scheduled for today. They are all very important as we're getting ready for our June 1st report to Congress.

We have this morning's session focusing on issues of information and quality. They are, to some extent, tied together, although focusing on different aspects than the first, with regard to informed consumer choice. Beth, Susan?

MS. DOCTEUR: A key component of the work on structuring informed beneficiary choice was --

DR. WILENSKY: Can you speak louder and into the microphone?

MS. DOCTEUR: Certainly. A key component on the work on structuring informed beneficiary choice was an expert panel meeting that the staff convened last month. I'm going to take just a few minutes to highlight some of

the interesting issues that were raised in that discussion. The commissioners have a more detailed summary of the issues that was provided in the mailing materials. Then Susan is going to highlight some of the key issues from the staff paper that we'd like you to weigh in on in your discussion today.

Fourteen panelists participated in the discussion. Panelists were chosen both because of the experiences that they brought as individuals and also because we wanted to have representatives of various perspectives on the panel. We did have representation from people who are working in the field of health care consumer assistance, persons who have been responsible for some of the cutting edge health care decision-making research.

We had representation from Medicare employees who are working to implement some of the Medicare BBA information provisions. And we had employee benefits purchasing executives. We also had others from health plans who could tell us about member information services and marketing issues.

Many of our panelists emphasized that choice can

be overwhelming, particularly for vulnerable groups. They noted that most purchasers provide at least a first-line edit on choices, narrowing them down effectively for those on behalf of who they purchase for. This is something that Medicare obviously has currently only a limited ability to do.

Many of our panelists told us that many beneficiaries lack a framework for decision-making. Never have never been before in this type of a situation where they need to make an informed choice about health care. Given that this is all new to them, our panelists told us that beneficiaries aren't yet fully recognizing and appreciating the potential benefits of being able to choose.

In the same vein, our panelists stressed that simplification of choices in the decision-making processes is key. They pointed to models for simplifying choice like the Medigap and the food labeling model, and to another, the financial planning or retirement planning issue, which is one that we hadn't discussed previously. This obviously has a lot of parallels in that it involves a series of complicated choices, multiple information vendors, and

standards for information content and presentation.

Many of our panelists pointed out that coordination is going to be a very important challenge that's particularly important in the context of Medicare decision-making. Under Medicare+Choice, beneficiaries have numerous options, traditional Medicare, Medigap, employer-sponsored supplemental.

They have multiple messengers bearing relevant information, including Medicare, employers, plans, consumer assistance groups. And finally, there are numerous items that need to be coordinated if choice is really to be simplified, including the messages that are used, language, terms, and benefits perhaps.

A number of our panelists raised questions about one of the messages that was a prominent part of this past fall's information campaign. For some, the message that you don't need to change from your current Medicare program might, in fact, be a disservice.

Our panelists pointed out that particularly those beneficiaries who lack supplemental insurance in the current system and are operating just with traditional Medicare

could potentially stand to benefit from plan enrollment to avoid out-of-pocket costs and to get additional benefits. Also, as we know, many QMB/SLMB potential eligibles are unaware of the possibility of enrolling in these programs and improving their access to care.

Panelists told us to foster realistic expectations. They stress that helping beneficiaries become more informed consumers has to be a long-term goal. There are different information needs at different stages and we can't do this all at once. Beneficiaries need to get first a handle on the basic concepts and the programmatic knowledge that allows them to operate in an informed choice environment.

Second, they need to have comparative information that they feel that they can use to make decisions. Our panelists, like some commissioners in the past, have observed that the Medicare population itself presents many challenges in terms of moving forward to helping beneficiaries become informed health care consumers.

This population is inexperienced with managed care, as compared with the employee population. There are

cognitive disabilities and low literacy rate issues that hamper communication. And then there's the issue of decision-making agents. This raises questions about when and how to educate and to inform when you're actually targeting multiple audiences.

Another interesting point that our panelists raised was the great value that many beneficiaries place on stability and security and certainty when it comes to their health care. Some panelists stated that if Medicare sought to lock in beneficiaries, the program should also think about ways to better lock in plans to things like the provider networks and drug formularies, for example.

Other panelists pointed out that there might be other beneficiary protections short of this type of a lock-in for plans that could also help to reduce uncertainty, having adequate disenrollment availability clauses, having strict policies against misinformation and marketing abuses, for example.

Another important finding from the panel discussion was a sense that the best information dissemination methods may differ from BBA requirements.

Those who have been in the field and had experience helping beneficiaries really told us that face-to-face personal assistance seemed to be one of the most helpful ways to get information across to beneficiaries.

This obviously raises questions about Medicare's role in funding issues and how this thing could be operationalized. They also told us that there's a lot of potential benefit from interactive, customized decision-making tools, although currently the best way to do this is through computerized systems, and that raises questions about the best way to make this available to beneficiaries.

They told us that the handbooks that Medicare put out this past fall were largely ignored by beneficiaries, partly due to a sense that there was just too much information at once and that many people felt that they couldn't process it.

I'll turn to Susan.

DR. ROWE: Is that it for the expert panel?

MS. DOCTEUR: Yes.

DR. ROWE: Could I ask a question about the expert panel? It says here in your summary, Beth, and I think it's

obviously an excellent idea to have an expert panel, that the panelists represent diverse perspectives, employers, health care purchasers, unions, health plans, public program officials, researchers, Marsha Gold, SCD, Robert Harley, Ph.D.

Were there any members of the group whoever provided health care to older persons?

MS. DOCTEUR: I don't believe so, no.

DR. ROWE: I would recommend that the expert panel's summary be reviewed by some individuals who have practical experience providing care and assisting older people with these decisions because I think that it's perhaps not certain, but it's possible that there might be some additional insight that could be gained there that would be helpful.

Almost none of my patients are on the Internet, but most of my patients can't read. So I think that we need to just embed this a little more in a context of a practical nature to it early on so we get some additional clinical input. Okay?

DR. WILENSKY: Any other comments before we go on?

DR. MYERS: Have I missed the list of membership of the expert panel?

DR. ROWE: No, it's published in the same page as the list of the other expert panelists.

DR. LAVE: Is there a reason we don't include the names of the people on the panel?

DR. WILENSKY: No. It was requested earlier and it will be provided. There are a number of other groups. I mentioned the Institute of Medicine had a workshop a year ago on this issue and I think we need to be sure that we indicate what we were finding and what was suggested to us either agrees or disagrees with what other such groups who have looked at this issue. This is not an issue that has been ignored. I don't know that we resolved it in any way, but it is an issue that a number of groups have looked at and I think it's important for us to have a sense about whether these recommendations are similar to or different from, and very much this issue about having practicing --

DR. ROWE: I'm not trying to be hypercritical here. I think the issue, obviously you can't have a bunch of doctors sitting around who don't know anything about the

field or the data. On the other hand, we have to push this through a bunch of filters to come out with some reasonable plan, an economic maybe filter, what can we afford. One of the filters has got to be a clinical filter that we have to push this through.

DR. LAVE: May I make another observation? One of the things that I did after I read this was that I looked up Medicare Compare and I tried to go through Medicare Compare for my zip code, and --

DR. ROWE: As a typical Medicare beneficiary?

DR. LAVE: As a typical Medicare beneficiary who even knew what to look for. I would say that it was not helpful. I mean, it was there, but it was not something that you would want to do. So the Internet may be a wonderful thing, but it's not there yet. I thought I'd put that out that I did go into Medicare Compare.

DR. WILENSKY: Susan.

MS. PHILIP: I will be continuing our presentation and going over the draft chapter on structuring informed beneficiary choice. I'd first like to go over what the intentions of Congress was in creating choices in Medicare

coverage options; then go over the different pieces that went into our analysis of structuring informed beneficiary choice; and then go right into the several issues that came from our analysis that we thought the Commission should consider in making recommendations.

The first slide. Congress intended the expanded choices available through Medicare+Choice to foster a quality-driven competition. Choice is important because of several reasons. It's a valued end in itself. It leads to a higher level of satisfaction. Consumers feel empowered because they have made the decisions in what products they purchase or what services they use.

Choices should lead to improved well-being, better health status for example. And finally, informed choice should spur value-based competition. Because consumers have the same information as the producers, they will be able to make appropriate choices and producers will then have to compete on the basis of quality, cost, and the level of services they offer.

Back in November, we presented a work plan laying out possible research strategies in approaching this topic.

Based on that discussion, staff perceived the following analytical approach. We reviewed the literature pertaining to decision-making theory and consumer choice.

We looked at the Medigap model. We did this by examining the Omnibus Reconciliation Act of 1990 and its provisions to reform the Medigap market and standardize benefits. The goals were to increase competition through Medigap carriers among Medigap carriers and help the elderly compare their supplemental options in making informed decisions.

The next model we looked at was the nutrition labeling model. Here we examined the literature pertaining to the Nutrition Labeling Education Act to see if this education initiative has met its goals. The goals of this reform were to inform consumers about their food consumption and create incentives for food producers to supply more nutritious products.

The last piece, as we just went over, was the expert panel. I don't want to get into the details of the findings of the different analytical pieces right now, but I'll discuss them later in the presentation in the context

of the different questions the Commission should consider in making recommendations.

In the context of our analysis, we looked at the current initiatives that HCFA is undertaking to educate beneficiaries about their Medicare+Choice options. From the slide, you can see that HCFA is doing several things in their national Medicare education program, including a mailing of a handbook, as we heard, to five pilot states and a bulletin to the remaining 45 states; a toll-free hotline; the Internet, as we heard; and local initiatives including partnerships with organizations such as the Area Agency for Aging, State Health Insurance Assistance Programs. These organizations partner with HCFA to run education campaigns and to counsel individual beneficiaries.

HCFA is also conducting an ongoing assessment program of each of their initiatives and this involves a great deal of data collection, both nationally and regionally, and they look at each component of their education program in their assessment.

Finally, the Consumer Advisory Panel on Medicare Education is currently being put together to advise HCFA on

how to reach and best educate beneficiaries.

Our analysis of the different consumer choice models and the decision-making patterns of beneficiaries lead us to raise certain questions about the state of current education initiatives, the first being, should HCFA have more flexibility pertaining to means of dissemination and information content of materials.

Currently, the BBA leaves out what sort of information should be included in the comparative information that HCFA disseminates. It also mandates how HCFA should disseminate this information. For example, the BBA requires materials to include area-specific comparative information about plan type, benefits, service areas, cost-sharing, and a host of different information. It also mandates that HCFA mail this comparative information, set up a hot line, and maintain the Internet resource.

We know from the decision-making literature that too much information could lead to overload. Either there's too much information for beneficiaries to even want to delve into, or once they begin, they're intimidated by the volume of information they have.

The next point. Employers need to counteract messages. The preliminary reactions from employers indicate a need on their part to counteract HCFA messages. Beneficiaries that have employer-sponsored insurance will more often have more comprehensive, less expensive coverage and employer benefit counselors have found a need to tell beneficiaries not to change their coverage or risk losing employer-sponsored Medicare benefits.

There's a concern about consistency of information between HCFA and Medicare+Choice plans. The information between HCFA and Medicare+Choice plans may not be consistent because of the volume of information that HCFA is required to disclose by open enrollment season.

Plans submit information by the ACR filing and then HCFA incorporates that information into their comparative information that they disseminate. By the time HCFA prints and mails out this information, it may be outdated, especially if plans choose to offer more benefits than they originally report to HCFA.

Current required means of dissemination may not be the most effective in increasing awareness or effectively

educating beneficiaries. Additionally, allocation of resources to specific medium of dissemination might not be the most cost-effective. For example, printing and disseminating a lengthy handbook might not be a cost-effective or a very useful mechanism to educate beneficiaries.

As mentioned, HCFA is currently conducting an assessment of their education initiatives and they might want to make adjustments based on their findings of their assessment.

The next question to be considered is about funding. Should HCFA's efforts be funded directly through the appropriations process rather than the assessment of user fees on Medicare+Choice plans? The issues to be considered here are twofold. First is one of equity. Medicare+Choice plans are essentially financing the education of all Medicare beneficiaries, not just their own members. Plans have questioned the equity of this financing mechanism since they are paying for the education of beneficiaries in traditional Medicare as well as in Medicare+Choice options.

There is also an issue of predictability. To determine the amount each Medicare organization will pay, HCFA calculates a proportion based on the amount Congress authorizes for collection in a given year and the projected revenues.

This proportion of assessed user fees changes as number of participating Medicare+Choice plans change. Participating plans do not necessarily have a way of predicting what the user fees will be in a fiscal year.

The next question deals with lock-in requirements. Should the timing of beneficiary lock-in be reassessed based on the assessment of the National Medicare Education Program and the level of relevant beneficiary knowledge at the time of lock-in, and that's set to start at 2002.

DR. ROWE: Is that the whole country at once?

DR. WILENSKY: Yes.

DR. ROWE: That's definite, right?

DR. WILENSKY: That's the law.

MS. PHILIP: It is phased in the first six months as open enrollment. The last six months are locked in for the first year, and then after 2003, the first three months

is open enrollment and then they're locked in for the rest of the year.

Over the next two years, the results from the evaluation of the National Medicare Education Program that HCFA is currently conducting and other research will give policy-makers a better understanding of how much beneficiaries know about their coverage options and how equipped they are to become active participants in the Medicare+Choice world.

Policy-makers can hopefully be less uncertain about beneficiary awareness then and be able to assess whether the lock-in is appropriate at that time. There are other issues related to the lock-in model that may be problematic. The lock-in model is based on the employer model which may not be appropriate for the beneficiary population, for example, snowbird or sunbird beneficiaries who change residence at different times of the year.

These individuals would be locked into a plan that may not cover out-of-service areas. Vulnerable groups, including those with low literacy rates and the cognitively impaired, may also make inappropriate decisions. While

protections are available for those who have enrolled in plans based on misleading information, those who are especially vulnerable are not likely to perceive complex appeals and grievances measures to prove they qualify to disenroll.

The last point is related to a concern that beneficiaries may be locked into a system that is in itself not locked in where providers, physicians, and drug formularies may change while they themselves are locked into the plan.

Plans remain fixed, but drug formularies may change during the course of the lock-in period and plans and provider contracts may alter during the lock-in period as well.

The next question is, should the Secretary evaluate the consumer information value of standardizing benefit package in certain markets? Here when we say standardizing benefit package, we mean standardizing the benefit package into an appropriate number of packages similar to the way Medigap was standard to ten different packages.

In considering this question, several issues need to be kept in mind. Standardizing benefits may hamper the plan's ability to construct benefit packages customized for the elderly or disabled. It may also stifle creativity in the Medicare+Choice market.

However, standardization might be the most effective method of increasing informed decision-making and promoting value-based competition. The evidence from the Medigap example shows that standardization of benefits reduced confusion among beneficiaries and beneficiaries have grown more accustomed to the ten Medigap options over the course of the years that it's been in place.

Related regulatory measures also did not drastically disrupt the market and, in fact, research suggests that the measures have contributed to a more tighter competitive Medigap market.

The next question is, should the Secretary research, develop, and require the use of appropriate standard terms in presenting Medicare coverage options? Should the carriers of this information, HCFA, Medicare+Choice plans, and Medigap insurers be required to

use such terms in their informational and marketing materials?

As beneficiaries are bombarded with information from HCFA and Medicare+Choice plans and supplemental insurers, the various terms used to describe the same things are confusing. Standardization of these terms may be the first step in comparison shopping and helping beneficiaries process the vast array of information.

Evidence from the Nutrition Labeling example suggests that standard terms and definitions is simplifying in something as, what is non-fat or what is low fat or reduced fat. These mechanisms have helped consumers to comparison shop and make decisions about the products they choose.

However, in this scenario, marketing creativity might somewhat be hampered by the standardization of information, but it may be a trade-off worth considering in helping beneficiaries compare their coverage options.

The next question is, when Medicare+Choice plans terminate their contracts, should beneficiaries be notified of their supplemental insurance options, of their

Medicare+Choice options, and the appropriate disenrollment and enrollment procedures? And should HCFA have to notify these beneficiaries within an adequate time frame?

In the last year, beneficiaries, when they heard that their plans were terminating, they were tempted to panic when they heard the news that their plans were terminating and many were not aware that they had to stay in their plans until termination if they wanted to be eligible for Medigap coverage.

If they voluntarily disenrolled, they were not covered under the Federal Medigap Guarantee Issue law. In such a case, beneficiaries need to be told of their options and appropriate disenrollment and enrollment procedures before the mass mailing during the open enrollment season in November.

Of course, requiring HCFA to disseminate more information would additionally tax their resources and that is an appropriate and important consideration. However, this beneficiary population whose plans have terminated are at least a group that is definitely facing the need to make a decision.

While most beneficiaries tend to need -- there are certain points in their lives that they need to make decisions. One is when they're first enrolling. The next is when their supplemental insurance becomes too expensive.

Another point is when their plans terminate, and another point is when their incomes or health status changes. So this is one situation where they definitely need to make choices about their plan coverage.

The next question deals with plan marketing issues and information protection for the vulnerable. Should the Secretary study the prevalence of aggressive marketing techniques or marketing abuses and should vulnerable populations such as the frail elderly and those without functional literacy be specifically studied to determine that their enrollment decisions are based on complete and accurate information?

Recent research has shown that marketing abuses among Medicare+Choice plans may be going undetected. These so-called abuses might range from non-deliberate misinformation to misleading marketing information. Those who are particularly vulnerable to marketing abuses include

the cognitively impaired and those with low literacy rates and non-English speakers.

While the Secretary has authority to investigate suspicious marketing practices, there is concern that not enough is being done in this new Medicare+Choice environment. That's pretty much it. I'm sure you have a lot of questions. If you have any additional recommendations or issues to bring, I'm sure you will.

DR. WILENSKY: Actually, there was a lot of information that was presented. There are a series of recommendations. Most of these are not issues that we have ever spoken on, so I think this will actually take us some time going through and we may do some catch up this afternoon.

DR. NEWHOUSE: I had a lot of reactions so I'll try to keep it brief. First, I think you make a plausible case to a disinterested reader that a lot of the current information efforts may be wasted or of limited value and that they may be on too small a scale, so what I'm about to say next doesn't really go to that point.

I want to talk about the discussion first -- your

discussion of the assumptions underlying the choice model, and this goes to how you would interpret the data you present and what we're trying to do with the information that's out there.

The first comment is that there seems to be an implicit assumption that the more people that are informed, the better, and that's not correct, I think. The first information itself is costly and getting more people informed is costly. Second of all, in theory, everyone doesn't have to be perfectly informed for markets to work well, especially with fixed costs. If some people are informed and shift based on performance changes, the market can work, in many cases, fine.

I'll give you the example of the U.S. auto industry. After the rise of the Japanese imports, I don't think any of us would think that everybody that bought an auto was perfectly informed about what they were buying, but enough people switched that U.S. auto makers changed their performance.

So it's very hard to know --

DR. ROWE: Changed their performance and/or their

marketing.

DR. NEWHOUSE: I think I would say changed their performance.

DR. MYERS: Thank you.

DR. NEWHOUSE: But the general point here is when you show us numbers that X percent did not understand this or that, well, the fact that X is greater than zero will always be greater than zero. So how you interpret that is open and I think there probably needs to be some framing of that in the presentation.

The second point is, there's an assumption that not only is it better if more people are informed, but that it's better if any given person has more information. You actually, at the end of the chapter, say that this isn't necessarily right, although that tone doesn't come through at the beginning.

There's kind of a nasty dilemma here, which is that it's clearly best to have perfect information, everybody have perfect information, but we don't live in that world and so it's always going to be imperfect and the nasty problem is that making it more extensive doesn't

necessarily get you better results.

The example you give at the end of the chapter that makes that point is that providers have an incentive to distort their resource allocation toward the areas you're measuring, if you measure some areas and not others, as in fact we do.

There's also some material in the literature showing that the better informed consumers are the worse the selection problem is. I mean, if everybody is totally uninformed, then people are basically just choosing at random and there's no selection, but they're not.

So I think we may want to adopt the premise that while we understand that more information isn't always going to be better, maybe that's what we're going to -- we're going to take as a rebuttal presumption that information should be better, or something of that nature, in any specific case for purposes of our discussion. Otherwise, I don't know how to deal with this issue, but I think it's a real issue and we shouldn't try to ignore it.

Now the discussion of the lock-in.

DR. ROWE: Joe, can I ask you a question about

that, if I understand the question and what you say. Does that take into account that certain parts of the market might be particularly at risk or particularly disadvantaged? It's different than the automobile purchaser. If we just said, okay, well, it's okay if not everybody understands this, it's always going to be the way it is, it really doesn't matter.

DR. NEWHOUSE: Well, no. It depends on the cost of informing them.

DR. ROWE: The more they know, the worse the decision-making is anyway, so we'll spend the money on the Internet piece for that group and then we won't bother with the ones that can't read it or something like that.

DR. NEWHOUSE: No, I don't think that's the implication. That's why I started out by saying there's a lot here that suggests that what we're doing may not be getting at what we want. This is more the, what do we make of the empirical data in terms of how we should think about it.

The way you're thinking about it is probably a way to think about it. Is there a group -- and in the case of

the very vulnerable, then the issue would be, well, are they using the same providers as potentially better educated people who may be able to discipline the market.

If the answer to that is no, and it probably is in many cases, then either the market doesn't work well for them and we need some potential other way to make it work well or maybe think about how to make it work better for them.

DR. ROWE: Because I can see us getting -- I mean, there's more than economics and market theory here, obviously, because there are rights and things like that. Let's say we decided not to spend the money to print anything in Spanish because that segment of the population isn't statistically significantly different with respect to how they're going to make decisions or who their providers are than the English-speaking ones and we only have X number of dollars.

That kind of a decision might be consistent with what I think I hear you saying, but it certainly wouldn't be consistent with what the Medicare program is about.

DR. NEWHOUSE: No, that's right. I agree with

that. Again, this was the notion that if we see a number that says X percent are not informed, that by itself shouldn't necessarily trouble us. I mean, another way to say this is, well, if X went to X minus Y, how much better should you feel.

DR. ROWE: Would you feel or what difference would it make.

DR. NEWHOUSE: Because it's never going to be zero. I think the discussion of the lock-in has to be brought in together with the chapter on risk adjustment. Now, I personally don't believe that a choice program is ever going to work well with a one-month enrollment period, and I'm actually personally comfortable with the law as it's written.

I would agree that one year is an arbitrary number and that, for the more vulnerable population, maybe it should be something less. I don't think I would dismiss that out of hand, but I am convinced that one month is too little based on the experience we've had.

This is a minor point, but I thought -- a couple minor points I thought I'd mention. The point about the

snowbirds, I think, is nothing I want to worry much about. First of all, I think the market may well evolve to serve them. Second of all, if it doesn't, then they'll stay in traditional Medicare and that's not the end of the world.

The point about physicians changing or your panel changing, well, that also happens in traditional Medicare. I mean, physicians retire and they move and so forth. I don't know. Maybe it happens more on the choice side, I don't know, I've never seen that data, but we shouldn't act as if this is somehow a problem that's specific to the choice plan.

DR. LEWERS: I won't be as long as Joe, I don't think. I agree with a lot of what he said. I think that Jack has hit on a point that is missing in this chapter and that is, the individuals do go out and seek the information they want, personal information. I'll give you some evidence of that. But they do talk to physicians, they talk to nurses, they talk to other providers, even occasionally to hospital administrators.

But that's the information that the source that they get. I still get calls every week asking about this

information, giving me a packet of information that's been sent to them that they don't understand. Quite frankly, frequently I don't.

The Internet, I think, in the elderly is becoming a source of information, but Judy is right. It is way too complicated. I have them bring me the print-outs because they certainly have trouble reading it on their computer. So they print it out and then they bring it to me and it is very complicated, but I don't think we can give up on that. I think there is a growing interest in the elderly in the utilization of computer information and the Internet.

I think an area that is also not included here and I think is a problem is carrier information. I think carrier education by HCFA is lacking. They are not consistent in their messages to the carriers and the carriers' messages, therefore, are far from consistent. So if your snowbird starts in Michigan and then ends up in Florida, they will get a different story altogether if they contact the carriers in those areas. So I think that's an area we should look at.

The AHA and the AMA had a project last year which

is still ongoing. It ended up being called the soup can project which I know you're aware of. Basically it was a labeling process and simple information should be provided by the plans. We did focus groups, the two of us together, and basically what we found out was four major elements.

One, the individuals wanted information about coverage of services. Secondly, they needed the information on the labels, but were really confused even by some of that simple information, so you really have to take it into a simple level.

The other thing is, they did not want information about quality. They tied it to two factors. One, they did not understand quality indicators. They secondly didn't trust the informational source. So quality wasn't the area they were looking for in the information they were reading.

The last is the point that you had made and I think we're all making. They want personal communication. They get very frustrated in the menus on the phones and many of them tell me they simply hang up when they find a menu. I know this is labor-intense, but I think if we're going to get there, that's the way we're going to have to function.

Just while I have the microphone on, two recommendations that I think are very important. One is the funding of the informational mechanism. We all have talked about the inadequate funding of HCFA in many of these areas. I think that is a critical one. And in the chapter, I think, should be the first recommendation that we make to Congress.

Secondly, I'm not so sure I want to see Congress at this point in time begin reassessing the timing of the beneficiary lock-in. I think they should evaluate it and consider it. I think that is a negative recommendation. It says we can't do the job. I think we should focus on doing the job and can always come back at the last moment if we're not there and our studies are showing that we're not there, then reassess it.

But at this point, we had a lot of debate about the lock-in. I think it's a very important period of time. I do not want to see us beginning to send the message that we're not going to make it and that that's not something that we should focus on. I think we still need to focus on it.

DR. WILENSKY: I'd like to strongly second that comment. I think the absolute worst message we could send right now is to move that date. If you want to absolutely guarantee we don't get there, telling them 2002 isn't going to be the relevant date is the way to do it.

There was a lot of very heated discussion on the lock-in, which is nine months, not really a year since you have the first quarter to change your mind, and I think saying now we didn't really mean it because we're not sure people will have enough information as of March of 1999 is just a really bad idea. Bill Curreri.

DR. CURRERI: I wanted to speak on the lock-in, too. I flatly am against this recommendation and I am not, as Joe has already pointed out, I am not convinced that the arguments for having a different lock-in are very strong for the reasons that he mentioned. I do think we heard very strong testimony earlier about the need for the lock-in.

I mean, that's what makes the Federal employer's plan work. It gives plans the opportunity to first of all budget appropriately, to decrease administrative expenses, to allocate their resources, and it's particularly important

as we face risk adjustment because you're going to have to risk adjust every month if you have it on a monthly basis.

So I feel even more strongly about it than Gail. I think it ought to be in there and it should only be changed if there's going to be a disaster that results.

MS. ROSENBLATT: I feel even stronger than Bill about the lock-in, so I'll just leave it at that. I mean, I think I'll just mention the words adverse selection potential and leave it at that. I strongly disagree with the recommendation.

I strongly agree with the recommendation about the funding and that the current way of funding the information is not a good method, so I strongly agree with recommendation number two.

Recommendation number five I have concerns about and I may be the only one in the group. Although the recommendation is only for a demonstration project for standardized plans, there is a message being sent in this chapter that the Commission is in favor of standardized plans, and this is a record that I've played before and I'm going to play it again.

I think that there are more negatives connected with standardization than there are positives connected with standardization. First of all, the paper does mention that the standardization to ten plans had beneficial effects, but that there was a lot of other stuff going on at the same time like different controls on the marketing and there was a lot of duplicate purchases and agents selling people duplicate plans.

I'm not sure that we can right now say it was the standardization that led to the good things or whether it was changes in marketing practices that led to the good things. The paper says that, but not all that strongly.

My concern, just to use an example Joe used before about the snowbirds, I mean, I do think that if the marketplace is left to innovate, that they might innovate and find a way to deal with the snowbirds, and I think that innovation and creativity on the part of the marketplace is extremely important and moving in the direction of standardization will just eliminate that.

I think perhaps right now the Medicare supplement market might be doing better things than it's now doing if

we did not have those ten standard plans. So I do feel pretty strongly about that.

Also, using the food labeling in this chapter I think is good, but just keep in mind that it's not stopping new products. It's just saying all these products have to have a standard label, and I think that maybe standard terminology and consistency in terminology might be a better message for us to send.

DR. WILENSKY: I'd like to also echo those sentiments. This was an issue that was raised in the OBRA '90. I had raised it, having the Congress try to go from a completely open marketplace where there were a lot of duplicate policies, a lot of questionable marketing policies, and to follow a path that actually Bill Gradison at that point at the Ways & Means Health Subcommittee had raised and along with some others drafted language to try to provide standardized information about how to present information on prescription drug coverage or availability of home care or private nursing.

Other aspects typically covered by some of the Medigap policies and to regulate some of the marketing could

have gone a long way to reduce the confusion and misbehavior that was of concern. When I read this, I think if I had not known what had gone on during the period, I would have thought there had been, at some point, some assessment about standardizing information as opposed to standardizing the benefits.

But, in fact, I know that has not ever occurred. There hasn't been any attempt to try to find out how much of the problem can be resolved by trying to control marketing and standardizing information and what the trade-offs are in terms of the kinds of policies that you can't get like the type of policy that would have responded to the people who move.

Or if you make an adoption, such as we've recommended with regard to home care, you have to legislate either the right to have 11 options, not ten, or knock out one of the ten that are in law, which seems to me a very peculiar way to have legislation. So I just think that this gave it a flavor of knowledge about what was done and what the implications were that I don't believe has occurred.

DR. NEWHOUSE: May I speak on this point?

DR. WILENSKY: Is it all right to have Joe speak on this point?

DR. LAVE: Sure.

DR. NEWHOUSE: Do you want to speak on this point?

DR. LAVE: Well, I was going to say something that was related to this point, but it wasn't that much.

DR. NEWHOUSE: No, go ahead.

DR. LAVE: I guess I was really going to make three different points here, so I was going to wander around a little bit. Why don't you speak on this point?

DR. NEWHOUSE: No, go ahead.

DR. LAVE: I guess the first thing is that I found this to be a very informative chapter and thought that under the first issue, that the role of the employers in the Medicare+Choice world is something that I think we ought to hit more in terms of how that information ought to be displayed with respect to the role of the employer.

It's obviously very complicated. People can't figure it out. I mean, we all sit here and advise smart people on how to make choices, so you can imagine how hard it must be for some people to make choices. So I thought

that that was very -- to me, it was useful.

I hadn't thought about that particular problem, about how, in fact, that ought to be addressed. So there were a lot of information things that I thought were important.

I think that the recommendation that we have here is a bit like motherhood and apple pie and I'm trying to figure out how we might be able to put more structure on it, about what it is about the current regulations that we don't like. I couldn't see that in there, about what it was about how really restrictive they were, so I thought that if we could flesh that out a little bit, it would be more helpful.

A word on the Internet. Obviously we're all looking towards the Internet. I think it would be very useful to have some study, we talked about beneficiaries, about which beneficiaries actually are using the Internet and to what extent are the beneficiaries who we classify as being vulnerable, you know, the one that we have this concern with who, I think, many of us probably feel that they might not use the Internet, maybe they do.

I think it would be very useful to have some

information about that.

DR. NEWHOUSE: There's also an issue about do their adult children use it.

DR. LAVE: Do their adult children use it? Because it would help, I think, probably if we looked at some of these things. So I really would like to do that. It seems to me that we are backing off the lock-in issue and whether or not we're going to address it here, I don't know.

But it struck me that in the discussion --

DR. WILENSKY: No, they're backing off. The Commission isn't.

DR. LAVE: No, no. I meant we're backing off the recommendation, but I don't know whether or not we're going to talk about it anymore. But as I read that section, it seemed to me that there were issues in there that were not particular to the Medicare beneficiaries and that they are issues that everybody faces and we've decided that that is not such a big a problem that we don't need. Like formularies change all the time. Doctor panels change all the time.

So this is not only a Medicare versus choice; it

also is something that affects the rest of us. So I guess my feeling was that one might want to look at -- if we're going to look at this at all, look at whether or not there are any issues which are particular to the elderly in this area, not issues which may be problematic for people who don't like this concept to begin with. So I thought that that was one of the issues.

Certainly, I thought it was very helpful because it did pick up on many of the problems that have come up. In number six, it struck me that that was one that was right on target. So I really felt that it would have been more helpful in framing this to sort of have some sense about what the constraints were that are currently in place and we believe, in fact, should be relaxed and changed.

DR. KEMPER: A couple comments. Just following up on -- I agreed with Joe's comment about how much consumer information. I think one point to bring out there is that the response of plans and providers to the information is extremely important, perhaps as important as the consumer response.

And so, some attention is needed to whether that

information is going to provide the right signals to providers and health plans about what are good quality plans and so on.

The second thing is, it seemed like the panel emphasized the fact of the complexity of the choice, that it's not just a choice within Medicare+Choice that the elderly have to make, but it's a choice between fee-for-service and Medicare+Choice. It's a question of what kind of Medigap coverage to get.

Then there's the issue of the QMBs and SLMBs not having information about those programs. So I think it would be useful to broaden the information campaign to include those issues as well as just do you choose Plan A or Plan B. Now, maybe that's a long-run objective rather than a short-run one, and the employer issue as well. So I'd like to see those things brought out a little more.

I agree about not having the -- not standardizing plan types, but I would extend that a little bit to a concern about the fourth recommendation as well about standardizing terminology.

I agree that terminology should be standardized,

but I think in the text, we ought to caution that that needs to be reviewed periodically because in this area, if you standardize the term PPO and had a clear definition of that, that in itself could limit innovation and so on. So I think there's a line to walk here that's somewhat different than in other areas.

I guess the last thing has to do with recommendation two about who should pay for the education efforts. It struck me that some of this arguably could be borne by the health plans, but that the bulk of it ought to be borne by Medicare fee-for-service and if the effort was broadened, maybe even the Medigap policies, but that there was a recommendation between the health plans paying it all and either general revenues or the trust fund paying it all and that we ought to consider sort of in proportion to size or share of the market how much is paid for.

DR. WILENSKY: Could you elaborate? I'm surprised. Is there any reason this shouldn't be a direct appropriation? I mean, I think this is just a direct appropriation.

DR. KEMPER: It should be a direct appropriation.

DR. WILENSKY: I think the notion that the provider community somehow ought to be responsible is just bizarre. I mean, this is a requirement that HCFA has.

DR. KEMPER: If you think about the non-elderly population, those education costs, marketing costs, I guess, are borne by that population.

DR. WILENSKY: But that population pays for its health care, and it's presumably put back into the price of the health plan. In this case, the public funds are paying for the health care and this ought to be part of running the program.

DR. KEMPER: All right. I'm persuaded.

DR. WILENSKY: I guess it just seems to me that there's a clear reason why this happened. They didn't want to appropriate the money for it. But other than that, I can't think of any reason.

DR. ROWE: I think some of the health plans aren't doing that well. Might not be really fair to ask them to pay for this.

DR. NEWHOUSE: I want to get in on the standardizing of benefits issue. First of all, I think we

may be in some danger of making a mountain out of a molehill. That is, I don't think it's possible in the end to standardize benefits no matter what.

That is to say, if I pick Plan A versus Plan B, to know that I don't have any expectation that if I had a heart attack six months from now that I would necessarily be treated the same in Plan A versus Plan B even if they had the same benefits on paper, that they covered hospital services and physician services, et cetera, et cetera, there would be presumably some utilization and review efforts.

Physicians might be compensated differently, all sorts of things. Plan-related variables could intervene that would lead to different treatment that I'm never going to know about. And even if I knew about them today, I wouldn't know what might happen six months from now.

So the kind of standardized benefits seemed a bit like the Holy Grail. Now having said that, sitting on the Harvard Benefits Committee, we tried to standardize benefits on paper across our plans. When we have the plans muscle back and say, no, we're not going to do it that way, it's a problem.

But we do that for two reasons. Actually the main reason is that we're trying to mitigate selection on benefits. So we don't like it actually if one plan has drug benefits and one plan doesn't because the people that are going to use drugs are going to go to the plan with drug benefits and that really makes our risk adjustment/selection problems worse.

The second reason we don't like it, which is more relevant to the context of this chapter, is the ease of comparison. Now, as against that, I give Alice her point about innovation and I give Gail her point that certainly the ten plans in the Medigap market are not the ten that I would have drawn up.

And we may want, as a Commission, to visit that subject at some point. But nevertheless, I think particularly the issues around selection are sufficiently serious that some kind of standardization is warranted here.

DR. WILENSKY: We'll obviously have some disagreement among the commissioners on that. I have Woody, Joe, Judy Lave, Alice.

DR. MYERS: I wanted to make a couple of quick

points with respect to the employer/employee relationship. Our experience is that most of our retirees really have very little idea of what Medicare covers. They even have less idea of Ford's relationship to Medicare with respect to their coverage and they really don't want to know the specific details of how that's changing and so on.

What we get is a very strong sense of fear that something is going to happen to disadvantage them. They want a lot of information, but we also agree with the point that they don't read the information that they want. What we have decided to do and what I think might be a model to think about is that the information is layered, that it's very simple in the first layer, it gets more complex and you can drill down in ways that you would choose to or your agent would choose to with respect to your own interest and need.

You get all of the basics very simply up front, telling them what they can and can't do, should and shouldn't do, and we are, in some respects, paternalistic in saying that you don't have to do anything, which is the message that many of them really do want to hear. So I

would add to your consideration the concept of layering of information.

The second point I wanted to make was that we shouldn't think of the Internet just in terms of the elderly being the end user of the tool. The Internet has a great deal of value and the technology has a great deal of value to those who could act as agents for the elderly, whether they are relatives or other types of agents, both in terms of ease of data collection and administration of the products.

So I would not dismiss the Internet at all and I would just look for other ways for it to be utilized other than directly by the individual at a terminal, which is the model that I think we're in some respects constrained in our thinking when we talk about that issue.

MR. MacBAIN: I'll try to keep this brief. On funding the education initiative, I agree it should be broad-based. It doesn't make sense to load it on just a few plans participating, but also, I think it makes sense to stress the importance of educating people on what the basic benefit is anyway before even get into choice. You know,

what are you comparing this thing to, and I think the paper points out that there's a significant problem just in people understanding their core benefits.

In terms of standardization, speaking of core benefits, the core benefit is standardized. That is, all plans have to offer something that's comparable to the existing Medicare.

Going beyond that I think is quite a bit different in the context of HCFA issuing regulations that establish something equivalent to the ten supplemental packages as opposed to the Harvard Benefits Committee. You don't go through a notice of proposed rulemaking, you don't have to respond to quite as many comments.

It's easier to change things year to year; whereas, we're looking at a much more cumbersome process and I think that Alice's part about innovation is very important. The inability of Medicare risk HMOs to offer a point of service product for a number of years was a difficulty in marketing to the snowbirds, for instance. So changing that allowed an innovation that the market had wanted to make for a long time but couldn't make.

Also, there's the concern that if you cannot compete at least in part on marginal additional benefits that you offer, you're really going to be competing just on price. Theoretically, you'd be competing on price and quality, but quality as we've seen is a very difficult concept to market. People don't absorb quality information and act on it in health care very well.

Nor is it necessarily instructive in the context of individual health plans. The quality that you get from the doctors you see, from the hospitals that you're admitted to may have no relationship to the mean data that's reported for a health plan as a whole across a whole market or whatever the database is.

There may be a lot more variation within plans than there is between plans, in which case you're not necessarily buying what you think you're buying, either good or bad. So for a number of reasons, I'm really uncomfortable about standardization.

In terms of standardizing terms, my only concern, I think it makes sense to all speak a common language, but to avoid having the definitions create more fog rather than

dispelling the fog. One of the things that popped to mind in this is not a Federal issue, but it has to do with a state regulation in which the definitions of subscriber and member in the HMO regulations were exactly opposite of the industry standard in the other 49 states and the confusion that that caused in terms of how contracts were written and interpreted, and it took a while to get that changed.

So just a word of caution that we may want to -- you know, something along the lines of a negotiated rulemaking or some input from the industry if we're going to have a common set of definitions rather than have them handed down.

The issue of agents and the importance of face-to-face communication I think we should stress a good deal more. The implication I drew from the paper is well, it's important, but it's impossible to do it as a policy issue. I'm not sure that we should dismiss it that readily.

This is a natural tendency anyway and there may be ways that HCFA could use a communication system that is already naturally developing. I think it was Bill who pointed out, or maybe it was Ted, the importance of

physicians in that communication stream as well as adult children and spouses and neighbors.

Again, I think that's something that we need to look at is, how do different types of agents learn about the different options, how do they communicate that to their patients, and are there ways that HCFA could support that process so that people are getting information from trusted sources.

This also, I think, has implications for how we look at marketing techniques. One of the citations of an abusive marketing technique, I think, was the health plan that required applicants to get a face-to-face presentation from a sales representative before they could join.

I'm not sure that that's abusive without any additional information. It seems to me logical to require it if people learn best on a face-to-face basis, to have a chance to ask questions and to hear directly from somebody in the plan.

That's colored somewhat by an experience I had in the early days of the Medicare risk program. I was with a plan that had a number of cost plan enrollees that we were

converting. It was the old two-for-one rule. For every two risk members you brought in, you could convert a cost member. Maybe it was one-to-one.

At any rate, what we found after a year or so of this was that the vast majority of customer service calls and complaints we had were from the cost members because we assumed that they already understood the plan. We were simply changing from cost to risk, but they didn't. They really had been using their cost plan as a supplemental plan.

The new members who came in on a risk basis from the outset all had some sort of individualized instruction, face-to-face or by telephone, and we found they understood the plan much better. So I think that it would be worthwhile focusing on the importance of the agents and of face-to-face education.

DR. LAVE: I want to sort of make two points, one on standardization. I think we should push towards standardization of terminology. You may want to have some protections on how in effect it's done so that it is reasonable so that the people involved in this are people

who are dealing with it.

I don't know how much of a problem this really is, but it does strike me that one of the things that happens is that you want an apple to always be an apple and you don't want it to be an orange some place.

On the standardization of the benefits, which is different, I think that to some extent, as I think about it, that is almost more of a philosophical issue and I don't know how I come down on that. I can tell you that one of the things that we did, for instance -- Joe, you're going to love this -- for risk adjustment, but we've been looking at all of the marketing material that a number of employers actually handed out to their employees.

Those who actually offered different types of options give people worksheets so that they can sit down and actually figure out exactly how much money they would pay under each of these options.

DR. NEWHOUSE: We give them that. We give our people that.

DR. LAVE: It seems to me that if you have different options and different worksheets, people are going

to risk-select. So once you have different benefits, you're encouraging it, I'm saying. It does strike me that one of the difficult problems is that you have this different philosophy between the extent to which you want to have different benefits because people are different.

DR. NEWHOUSE: Yes, that's right.

DR. LAVE: And I think it's a philosophical issue.

DR. NEWHOUSE: That's right.

DR. LAVE: I want to ask something about the face-to-face thing. There are lots of different ways of doing face-to-face and one way of doing face-to-face, the way they do face-to-face in our university, for instance, is that the university holds sessions whereby the people from the plans come and talk about what's going on.

So you have face-to-face interactions in a controlled setting. So you could do the same thing for the Medicare beneficiaries. You could have face-to-face interactions with the plans supported by areawide agencies of aging, supported by the churches.

What it does is give you a non-threatening way of soliciting the information and making sure that the

information is not abusive. So you're correct, but I think that one has to be sensitive about sort of how, in fact, that happens.

I can tell you again, this is anecdotal, in Pittsburgh, there are some old people who do not want to pick up the phone because they figure that, in fact, it's going to be somebody trying to sell them something that they don't want. So I'm more comfortable with where we are in trying to figure out innovative ways of giving face-to-face individual contact, including having the plans involved in providing information in non-threatening circumstances.

DR. WILENSKY: Alice, and then I'm going to turn to the individual recommendations and quickly go through them.

MS. ROSENBLATT: I just want to make one more comment on standardization in response to what Joe just said. I don't think we're making a mountain out of a molehill, Joe, because I think that some companies would say that one of the things that they bring to the market is the ability to respond to marketplace changes, new marketplace needs quickly with new products that meet those needs.

I know my company, for example, considers that very, very important, our ability to design new products, to get new products accepted quickly by various state insurance departments. It's just very, very important to us.

DR. NEWHOUSE: Give me an example of a new product.

MS. ROSENBLATT: One of the things that Blue Cross of California did -- this is on the commercial market as opposed to Medicare risk, but I'll just use it as an example. Most PPO plans had deductibles of, let's say, $200 if you were in network and $400 if you were out of network. Whereas, HMOs had copays.

Blue Cross of California was the first company that introduced a copay PPO plan, which has now been copied by a lot of the marketplace. But had there been a standardized set of benefits, it just would have been a lot of effort to make something like that happen, and the marketplace reacted very favorably to that product introduction and probably gave us -- I don't know how we came up with the idea of doing it, but I'm sure it was through input from the marketplace.

I think what Bill said is very important, that the Harvard Benefits Committee is probably looking at plans all the time. The plans have the ability to talk to that benefits committee and say, you know, we've got an idea, we'd like you to consider this. It's not like getting a law changed to introduce a change in benefits.

DR. NEWHOUSE: No, I agree with that point.

DR. WILENSKY: I have also heard the issue raised that, for example, it would be possible to slow down the rate of increase in the Medsupp for Medigap if you could use copays on a selected basis, but because of the ten plans defined in the statute, you can't begin to go do that.

It has really impacted the ability to take what people in the private sector, commercial sector are learning and adapt it to try to provide a better benefit for seniors. I think it's an issue that really gets raised on this limited standardized benefit. Spence and then I think we really need to get through these recommendations.

MR. JOHNSON: Hopefully after listening to the long conversation, this will serve as my off-the-wall comment for today. It seems to me, looking at long-term

solutions and recognize Bill mentioned adult children and other networks that the elderly turn to, I certainly don't know too many are going to do worksheets to find out which plan they're going to produce, at least not in my mind, but maybe we ought to be looking at public education which has gym courses on physical health, certainly courses on history and government, and maybe we're going to be at the point in this country, since a lot of the adult children are going to be called on to take care of a lot of the baby boomers, that maybe in secondary education, we need a required course on Medicare and what it is and a test you have to pass before you could graduate from high school.

Maybe in the long term, that will do more to solve some of these problems than what we're certainly going to have in the short term. Anyway, that's my off the wall comment for today hopefully.

DR. WILENSKY: What I'd like to do is to, hopefully, quickly go through the seven recommendations. This is not your final cut at them. For most of them, I think we've heard some discussion, so I'm going to just try to summarize, yes, I think that we are generally in

agreement with some, either as is or some redefinition, or this is not in agreement and please respond as you think approximately.

With regard to the more regulatory flexibility to HCFA in terms of relaxing various requirements, I think the issue about whether or not providing more flexibility to HCFA as opposed to putting everything in statute was one that seemed to generally be supported.

The issue as to whether or not there are specific examples as to the kinds of rigidities that we think are present would be useful, but that seemed to generally be supported, or at least nobody was indicating lack of support.

Similarly, my sense is that people were comfortable with the notion of having a direct appropriation for education.

I think we ought to just eliminate number three. I strongly supported Ted's comment where in 2002, we can say stop if we think there's a problem, but to indicate anything now is to invite a problem. Also, too much blood was shed on that particular issue during previous commissions to want

to undo it at this moment, which Beth may or may not remember from our PPRC discussions.

With regard to the use of researching standard terms in presenting coverage options and using some of that information, that actually seemed to me, with some of the concern raised about what that might do, generally supported, that is, the notion of using standardized language.

MS. ROSENBLATT: I think with the caveat that Peter brought up, yes.

DR. WILENSKY: Right. So I think there was support there. My sense, although I don't want to over-read this because of my own position on this, on number five, is that there is not a consensus on number five.

DR. NEWHOUSE: But I think maybe we could have some discussion of the trade-offs involved --

DR. WILENSKY: That's fine

DR. NEWHOUSE: -- in number five.

DR. WILENSKY: That's fine. In the discussion with regard to risk selection --

DR. CURRERI: Just not have a recommendation.

DR. WILENSKY: Exactly. With regard to number six, we didn't really have much discussion to the point about whether there is adequate timing. We may want to just let this ride and let people try to think about this for next time when most of the response was provoked by these other issues.

It might help us if you could give us, in the discussion, something about what kind of timing you're thinking about and if assume HCFA moves in the direction we suggested last time, which is to provide plans until approximately July or August to put in their own premium benefit information, what does this mean in terms of the timing.

DR. CURRERI: I also think we should put some quantification in the chapter with regard to that. I mean, what we say in the chapter, as I recall, is that there was some evidence of panic and people withdrew before when they had to stay in the plan, but there were no numbers associated. So I don't know whether that's a big problem or it was a regional problem or what. If we're going to say this, we need to better quantify it.

DR. WILENSKY: Finally, on number seven, this may be something that some of you who are more directly involved with marketing issues can tell me. I thought there were all kinds of laws on the books controlling aggressive marketing techniques and preventing marketing abuses.

If there's an issue about whether they're enforced and whether we might want to make a recommendation about better enforcement, at least my sense is that this was not an area that was outside regulations and statue.

MS. DOCTEUR: I think the purpose of this recommendation was to have the Secretary specifically do some studies to see the extent to which there are problems as opposed to necessarily strengthening the existing laws.

DR. NEWHOUSE: That's the first sentence. But the second sentence talks about complete and accurate information, which seems like an impossible goal.

DR. WILENSKY: I think these may be two separate recommendations. The first one is saying study where there's a problem. The second, I don't know. You may want to go back to think about the issue of what is it that we would like to do for the vulnerable populations with this

respect. Is it that this is something that can be appealed for people who, in fact, have literacy problems or have dementia issues.

I was a little concerned about what seemed to me too offhand or flippant a response that these are the populations that might not challenge it. Well, okay, at some point, if you put in provisions of protections and you hope that you had agency on aging individuals who can act or adult children who can act on behalf of parents who are part of the vulnerable population, I'm concerned to just dismiss that. So if there's something else that we want to suggest, that would be fine. Bill?

MR. MacBAIN: I think, particularly given the BBA requirement that one-third of the plans, third of the +Choice plans be assessed every year anyway, this is going to happen. It's a little like telling a fish to swim. It's part of what HCFA does.

But I do think that there's an issue there, that I would reframe this in terms of studying how beneficiaries learn and make choices, what the role of agents is, agents broadly defined, I think, to include physicians and other

health care workers and volunteers and area agencies on aging much broader than just immediate family, and how the agents learn and the extent to which the agents are effective in transmitting accurate information.

I'd much rather put the focus on that, of what other kinds of marketing is going out there that we can take advantage of and to what extent is that beneficial to beneficiaries in making their choices.

DR. WILENSKY: Let's also be sure to do this in context of the many other activities in this area that are going on. I had mentioned that I had seen documents related to an IOM workshop that was held in 1998. A paper was commissioned and many of the people cited in our chapter were involved in that. I just want to make sure that we're not going to direct yet one more to do something that 18 other people have already done.

MR. MacBAIN: Maybe we can call it a meta-study if it's already out there.

DR. KEMPER: I'm not sure I followed exactly where we're headed on this one, but I would just like to put in a bid for the Secretary paying attention to the aggressive

marketing in vulnerable populations because there's a history in Medigap of problems there, there's a history in long-term care insurance. They may not be prevalent, but they could have very adverse effects, even if it's a relatively small number on the whole Medicare+Choice.

DR. WILENSKY: I think right now what we're suggesting is that because there are a variety of regulations and laws that govern against this, that we direct for a study to try to assess how prevalent it continues to be in the presence of these laws, to try to decide whether it's the enforcement that is a problem or whether there are still some areas that need to have additional enforcement.

DR. NEWHOUSE: I have some suggested language. So we do the first sentence, the Secretary should study the prevalence of aggressive marketing techniques or marketing abuses and then we just go on, especially among vulnerable populations such as the very frail beneficiaries and those without functional literacy, period.

DR. WILENSKY: Okay. Let us move on to the quality assurance in traditional Medicare. We have

obviously substantially exceeded our time. These are very important areas and I think it's appropriate that we give them their due and we will either make up the time this afternoon or not.

DR. NEWHOUSE: Should we do the quality and errors discussion together?

DR. WILENSKY: Yes. We're going to start with the errors discussion first in response to some of our honored guests here who are sitting patiently.

MS. DOCTEUR: As you know, you had an extensive first discussion of most of these issues in November and this iteration includes draft recommendations based on both the analysis and the initial discussion that you held in November. There is a new section on medication errors that was added to this version in response to some issues that came up in November.

I'm going to be very, very brief in trying to just remind you of what the key issues are, the conclusions that the chapter draws, and put before you the recommendations because I think they require some discussion.

Let me just remind you, the draft chapter includes

three separate but related policy analyses. The first one is, what is the right role for Medicare in addressing health care errors generally. The second one is, should Medicare take steps to increase appropriate autopsy use, to identify errors, and increase the ability to learn from them.

And then the third one is, should Medicare take steps to reduce Medicare errors -- excuse me -- medication errors. I would suggest going through these separately, having a discussion of the first issue. Let me just remind you of what the issues are, discuss those, move on to the second issue, discuss those, and the third issue. Does that make sense for you? Okay.

I think it's worthwhile pointing out what the inputs to this analysis were. First of all, there was a review of the research literature characterizing the problems, evaluating solutions. There was an inventory of current initiatives, particularly national initiatives that are part of the current patient safety and error reduction movements.

Third was an assessment of current and potential Medicare policies. And finally, you saw that the staff

paper included explicit consideration of interested parties' policy positions and rationales, and I mention that because you should know that lots of groups are interested in your position on these issues. I know that several people do plan to speak to you on these issues during the public session.

Let me give you a very brief reminder of the issues relating to Medicare's role in addressing errors. The conclusions drawn in the paper based on the analysis are first, that errors are a critical health care quality problem that often account for unnecessary costs and adverse events.

Second, that Medicare errors can be prevented in many cases, particularly those that are inevitable because of poorly designed systems and processes, which makes this an attractive health care quality issue from a policy perspective.

Next, numerous initiatives and interventions have arisen to address errors by using techniques like root cause analysis and some of the other techniques that are described in the paper.

Next, the paper cites works that suggest a great potential to reduce program costs and improve beneficiaries' health by taking steps to reduce error through the Medicare program.

If Medicare is to move forward, barriers to success must be taken into account, including those raised by the professional liability insurance system, the medical professional culture, and others. Medicare and the health care industry in general can learn from other industries like aviation and nuclear power.

Medicare has numerous available policy levers for influencing error and those that are discussed in the paper include payment policy, conditions of participation, quality improvement requirements, and public reporting.

The paper offers three proposed recommendations for your discussion. The draft text is in the chapter. Basically the issues are, first, should Medicare make error reduction a quality improvement priority, something that it hasn't done to date.

Second, should the program use its available policy levers in efforts to reduce errors, taking error

reduction potential into account, for example, when making coverage and payment decisions, in defining performance measures for public reporting.

Finally, should the Secretary examine the feasibility of implementing an error reduction system similar to, for example, the one that's used in the aviation industry now that would involve features like confidential error reporting, root cause analysis, pattern analysis, education, and feedback. I'll stop here for your discussion.

DR. ROWE: I think this is very, very important, increasingly recognized as important. I think the material in the chapter is very important. I'll be very happy to hear if that's done. There are a couple of things I'd just like to underline. I think your reliance on Lucian Leek's work is appropriate and good. He's certainly a leader in the field.

I think the emphasis on moving the whole population to the right to improve quality and reduce errors, because many of them are system errors as opposed to the bag 'em and tag 'em or line up the bad guys and shoot

them approach is very clear. It's consistent with the direction the field is going in.

It is absolutely inconsistent with altering the conditions of participation in Medicare recommendation that is discussed at the back of the chapter. I mean, how can we ask providers to report on errors? How can we take a consistent approach to this? How can we recognize that the perfection is probably difficult if not impossible to achieve and then go and talk about, as we do on Page 29, that it has been recommended by HCFA in a proposed rule to limit a zero tolerance policy for "significant medication errors" with respect to the conditions of this.

I mean, I just think that I find those things difficult to reconcile, and I'm concerned that this nuclear warhead kind of threat would have a chilling effect on what is a significant and growing movement in the field to reduce errors. So that's one thing I'd like to hear other commissioners respond to.

DR. WILENSKY: Is there a specific though -- the language of the recommendations -- I agree with what you're saying. The language of the recommendation, I guess, I

regarded it as one that a condition of participation was more in the requiring of use of error reduction strategies as opposed to --

DR. ROWE: Right, there are two. I think that's right, but I can't resist commenting on the material on page 29 where it does indicate that under the new conditions of participation, Medicare participating hospitals would be required...to establish a zero tolerance policy for significant medication errors. To have that and at the same time try to encourage people to report errors, I think we should just say something about that.

My concern is, you know, a couple minutes ago -- and I think this is an important issue -- Joe made a very good comment about how we had a recommendation saying that we should have absolute information and perfection or no errors in some information and it's not achievable.

Right now when we have errors in our billing, it's interpreted by some people as fraud and abuse and physicians are threatened that they're going to go to jail. Well, if a nurse makes a medication error, are we going to send her to jail? Is that what's going to happen?

People would say that's ridiculous, Jack, but come to my hospital and meet with the OIG and talk with him about it. So I'm concerned that we might be putting this into the same category as those kinds of errors and in the current environment, I think that's counterproductive.

A couple other things. I think that the pharmaceutical industry has some responsibility here in the medication things and we should mention it. Wouldn't it be helpful not to have all the drugs have the same name? I mean, how can the patients tell the difference between the drugs? They all have the same name.

Wouldn't it be helpful to get some of the drugs, the solutions have separate different colors or something so a nurse can walk in a room and tell whether a patient has it going in or not, or something of that type. We need a little help from the pharmaceutical industry and we haven't gotten much.

We're blaming it all on the providers here, but I think that there is a value to some participation with respect to that. I think that it would be helpful, Beth, to add a little more granular detail on the implications of the

changes in health care, the way the production and distribution of health care services and how that might influence the likelihood of error.

More providers, more handoffs between one provider and another provider, different locations of care, patients not staying in the hospital as well as going from hospital to step-down unit to home care to rehab unit and what the implications are for all those different shifts and the systems that we have to put in place to reduce errors.

I think the Veteran's Administration has been national leader in this. You mentioned the VA program. There are some additional advances with respect to that that I think are very worthwhile to include. I think it might be worth including a specific paragraph about some of the experience with care plans.

I mean, one of the ways to reduce errors in hospitals is to -- as well as short length of stay and maybe even reduce some of the variability in costs is to develop and implement care plans and keep people in the plan and that reduces some of the variance, and I think that's a specific area in which there's been some experience on

protocols and use of certain medicines like heparin, which is an anti-coagulant. If you're given too much of it, it can have an adverse effect on bleeding. You can reduce the likelihood of that happening.

So there are some specific responses that have been developed and I think it might bring things out of the page a little bit with respect to this. I'm delighted that we're doing this chapter. I think this is really important stuff.

DR. WILENSKY: Let me share what I'd like to do as we go through this session. We'll do this one. We'll go through the other recommendations.

Before I ask you for a sense or a vote or consensus on these recommendations, I'm going to ask for a response from our public here. We have an unusually knowledgeable group and I think before we ask for some consensus on where we are in our recommendations, I'd like to have that participation. Then we'll come back, if no one disagrees.

MR. MacBAIN: I agree with Jack, this is an excellent start at looking at this issue. There's been a

lot written from quality improvement in manufacturing dealing with these same kinds of issues. I think it would be helpful to bring in more outside examples to underscore, first of all, the importance of removing the punitive aspects, whether it has to do with conditions of participation or treating an errors or violation under the False Claims Act or some sort of fraud or abuse.

Secondly is the importance of focusing on systems rather than individuals. You make the point, but I think it needs to be made over and over, because in looking at errors in medicine, the standard for so long has been to focus on individuals that it's to the point that it's to look at individuals rather than systems.

I mean, individuals are there, individuals provide care, that's a given, and individuals are flawed. So if you're going to avoid error, you have to have back-up systems, redundancies, better information, things that take into account the fact that we're relying on individuals rather than simply saying stop making errors.

You make the point, but I think it needs to be made probably a couple more times, drawing examples from

other industries.

DR. MYERS: This is a very important topic, but I would perhaps disagree a bit with my colleagues. I think that the zero target is an appropriate target. I think that getting people in the mindset of thinking about a zero target is the appropriate approach.

We have been amazed with what we have learned within industry and I will be the first to suggest that there is not a 100 percent analogous situation in hospitals, but we've been amazed at what we've learned in industry by setting those kinds of targets and working very hard to achieve them, what can be done.

So it is the right target. The question is, is there a range of consequences somewhere between complete immunity and public execution, and I think that there is. The consequences can be system or can be facility-based or can be individually-based, and I don't think we yet have the right formula for what those consequences should be, but we should set the target.

It is absolutely clear to me that our industry, health care, that our approach with providers is way behind

other industries, other groups of individuals trying to achieve goals with respect to our use of processed technology, with respect to our use of information technology, and it's now time to make the decision to use it properly and to get the number of medication and other errors down to zero as quickly as possible.

Unless there are consequences of some sort, you will not drive the behavior as quickly as it should be driven or as aggressively as it should be driven towards zero.

DR. ROWE: Can I respond to that very quickly? I think there's a difference between a target and a required level, and I would certainly not feel that it would be appropriate to have a zero required level for errors in the manufacture of automobiles and if one Ford product is found to have an error, then Ford be forced to go out of business and liquidate.

I think it would be probably inappropriate, but that's what we're talking about, if we have a requirement for zero tolerance in the current environment in which the way the OIG and others are responding to issues in health

care. I agree with you, Woody.

Maybe we need a variety of different scaled kinds of reactions, but the carrot is better than the stick in this. What we're learning is that we should require significant -- just like the joint commission has sort of changed their approach to this -- require significant commitments on the part of the institution to detect and reduce the number of errors.

But my concern is, if we put zero in there as a target, it will be converted by some to zero as a requirement and it wouldn't work in health any more than it would work in the auto industry.

DR. WILENSKY: I think this is just a language issue. I think you can deal with it, the importance of recognizing the goal, but to put the emphasis in the required response on the systems to reduce it. I agree with the sense of it. Let's see whether we can have that conveyed in the language. I have Spence, Bill Curreri, and Hugh.

MR. JOHNSON: Now that Woody has brought it up on a more personal note, I'll talk with you later about my Ford

Explorer in the shop at the dealership in Pataski with the transmission problem that they told me would be fixed in a week, that they're now ordering from California.

I agree, this is an important topic and that providers should be held accountable for having a process, and I think we're going to have a long and sprightly debate on whether targets or requirements are the first stages of that process or not.

I'd like to go to Page 7 of the draft language where it talks about action by professional liability insurers. I'm going to make the comment because I happen to be a director of two different liability companies in Michigan.

I'm just concerned about the way this starts out about actions by professional liability insurers, which is sort of a guilt by innuendo statement, and while it says some, when you put things in these reports, they assume a much larger importance.

But I know in one of our companies, while it's important to find the errors, in the last five years, we've actually started something called risk Rx, which is

requiring all our insured institutions to send their risk managers actually to schools for certification on how to find errors, how to deal with them.

We actually have a reporting mechanism for things that do occur, but more importantly, we teach them about how to go out and look for instances in their facilities and how to identify treatments or processes where there might be errors and to do something and educate folks about them before they happen.

So I think the first paragraph is sort of a knee-jerk, the old days way to look at things, and actually, I'm not even sure it's the insurers. It's those lawyers that want to defend everything. We have to watch who we blame here.

But I think that there are a lot of thoughtful companies out there that are trying to do something prospectively and in a preventive nature in terms of dealing with errors and there's really a different view being developed about liability coverage and what has to be done in that area, and I know Ted has some experience in this area as well.

DR. LEWERS: If I can just comment on this point. Beth, I didn't have anything to say on that page, but Spence is perfectly correct. This sounds like it was written by a plaintiff's bar associate and it basically really demonstrates a poor understanding of the policies of the liability carriers.

There may be some who have some of the factors that you have there, but it's few. The policy is not to slide these things under the carpet and forget them. You make the statement that policy for fighting all lawsuits is a bad case.

I don't know of any company who have that. They quote some of that, but there's just a lot of inaccuracies in this section. We run, for my conflict of interest, I do chair a holding company with four liability companies under it and I guarantee you we have none of these policies. We have the reverse.

We're the sixth largest group in the country. We really want to get out there and put this information out. We want autopsies. We want to be able to have it. We win more cases with autopsies than we lose, and so we really

want them and we push it in our risk management program, which is very extensive.

I think the point you take about university consortiums have taken the opposite tack. I would challenge that. I'm working -- I can't tell you the universities, but several facilities in which I work directly with them, and I can tell you that one of the issues of why they work to settle cases so quickly is so that it doesn't get in the media, because the settlements are closed and you don't get any information about it.

So this chapter on this part and the threat of the malpractice, which again I want to get to my liability word, litigation, again, that needs major rewrite. I'll be very happy to help you with it, with my full conflict exposed, but this area is not what is in the world today.

DR. CURRERI: I think this is a very important chapter, but I also had a lot of trouble with it and I think there are a lot of inaccuracies in it. First of all, I've had a lot of experience with a good error reporting system and if you want to look at a good model, the University of Alabama Medical School had instituted that in about 1986 in

which there was active examination of risk and active reporting of errors.

We found two things. One, it helped us in eliminating systematic errors, as you mentioned quite appropriately in here, and secondly, though, and probably more importantly, it much reduced the cost related to errors.

The reason for that was that we found the quicker the error was recognized, then the quicker the error was brought to the attention of the patient or the family or whatever, anger hadn't developed over it and there was time to make reasonable restitution for whatever the error was.

So if a man fell out of bed because a nurse forgot to put up the bed rail and got a little laceration, we made adjustments in the hospital cost and both family and patient and physicians were happy.

But we found if we let it go by two weeks or two months and lawyers started getting involved, the longer it went, the price got higher for both sides, the patient and the provider. So there's two benefits to it. One is that it gives you a framework for improving systemic problems

that can prevent errors, but more importantly, it really reduced the cost of inevitable errors that occur.

Now, I have some real objection. I don't know who made the comment that you quoted from Blumenthal in 1994 and I didn't have a chance to look that article up, but I think that that one comment is totally inappropriate. I, in 25 years in academic surgery dealing with all kinds of physicians, have never seen that and if you're going to put in that comment, I think you have to put either some explanation or where the justification for that is. It looks like somebody's thought, to me. I think it's nonsense.

Third, you comment about the VA, and the VA has done a lot, as Jack has already pointed out to you. I don't think it's quite comparable to the civilian situation in that it's very difficult to sue the government, as you know. In most cases, you have to get the permission of the government in order to sue them.

So that many of the things done in the VA are a totally different system because there's really no threat of malpractice suits and there's no threat of suits against the

hospital in most cases, unless there's clear negligence involved. So although the VA has taken the lead, I don't think they're comparable models.

Now, the Federal Aviation model, I thought, was a nice model, but then I thought it got a little schizophrenic here because recommendation number two suggests that we ought to penalize those people that aren't reporting errors, which is just opposite of what the Federal Aviation Agency does.

They agree if there is prompt reporting that there will be no penalties or fines. So we need to straighten that out because it seemed to me that was a total dichotomy.

Now I'd like to make a real plea that somehow, if you're going to have widespread reporting of errors by providers, whether they be hospitals or allied health or physicians or nurses, you're going to have to somehow provide them confidentiality from subpoena, because if you don't have that, they're still going to be liable, and if they report this material and it leaks out or it can be subpoenaed, then you're asking them to put themselves at very high risk for mental anguish and financial disaster.

Nowhere in here do we discuss that. So somewhere we have to come to where this can be -- if you want it to be reported on a uniform basis and you want it to improve the system so there isn't systematic error, you're going to have to assure these people that are providing this information that it isn't going to be leaked out and used against them in a civil suit, in my opinion, if you want it to work.

And then, I think those are the main comments I wanted to make. There are a couple minor things, but I'll talk to you about that later.

DR. LONG: Basically my point is the last one Bill was making. Whatever other inaccuracies appear on Pages 6 and 7, it certainly is true that the majority rule is that information generated internal to an institutional provider is shielded from discovery in almost all states, but the second that information departs the corporate boundaries, it is discoverable.

We point this out, correctly, I think, in the chapter, but then just let it hang there. I don't think we want to get over into tort reform particularly, but clearly, if we want to go down this road, we're going to need to do

some further research or have some further recommendations as to how, in fact, you protect confidentiality, avoid the chilling effect of reporting, and keep this in an arena that's not going to be immediately admissible in a court in a liability action.

DR. LEWERS: I just want to agree with Bill Curreri on the statement on Page 6, and perhaps for the audience just read that quickly because they're probably wondering what we're talking about. There's a quote from Blumenthal in '94, and I didn't find that paper either, but, "Physicians are encouraged to hold themselves to unattainable standards, to deny evidence of error, and thus to overlook opportunities for improving themselves and the health care system as a whole."

I strongly disagree with that statement. I do not think that I know of any area where that encouragement is going on and it certainly is not taught in medical school.

DR. ROWE: Well, David is at the Mass General Hospital. Maybe there was something deleted here.

DR. LEWERS: I doubt they teach that there.

But I think the other point is that in our

recommendations, I think we should add one and that is, let's not reduplicate it and reinvent the wheel because I think we should have something that the Secretary should work in a public/private sector initiative.

The National Patient Safety Foundation, which you comment on in here, as an AMA-endorsed or sponsored, is really an independent organization. I mean, that is a group of individuals around that's funded in part by the AMA, but funded mostly by outside agencies. There are people in the audience who can tell you more about that.

I think that as we get into recommendations, that certainly has to be one. The same thing we said the last time. Let's just not go off on a tangent because we are the big brother government.

The other is the issue that Bill brought up about the sentinel events with JCAHO. One of the problems with that, one of the things that stopped that was the immediate reporting that becomes public knowledge, the media gets involved, and so the physicians are again guilty before they ever get a chance to hear, or other providers are guilty.

We've got to get away from the punitive approach

in this and make it an educational approach and seek what Woody is seeking, but you've got to understand. We are dealing, you know, our patients are living individuals that have some impact on the whole picture. So I think that we've been too long in the punitive nature and I think we begin to work together to solve what is a critical problem.

DR. WILENSKY: I want to challenge this. Several of you have commented about the professional culture. Now, it's a hard issue to write about and it may be we either have to have more discussion of that or not take it on. It's hard to do in four lines.

But I disagree with the comments that have been made. I think that is a part of the professional culture and I'll cite the hours worked by residents as an example. This one was one of the meetings on error reduction that I have attended recently. It was a closed meeting and so maybe some of the physicians were willing to say things in private they weren't in public.

But the quip was made that medicine seems to be the only industry where it's believed that fatigue doesn't lead to increased errors. That's the only way you could

acknowledge the kind of behavior that goes on in terms of the number of hours that residents work and the expectation that that's not going to lead to increased error on their part.

I think this notion that there does seem to be, as part of the culture, that you can do it and there won't be any adverse consequences just flies in the face of what we see going on in the airlines industry, where I'm sure many of you have been on the airline and been sitting on the runway, all of a sudden get the announcement, we're going to turn back because we've just exceeded the pilot's time allowed for flying.

I mean, absolutely scrupulous to the minute as to how much time can be had, and then you think about what happens with residents in neurosurgery in hospitals and when they're having their operations.

It may be that this is such a big issue and controversial and not quantitative by its nature that we either have to have a chapter about medical and professional culture or we ought to bag it, but I don't agree with the sense that this is not an issue. I think it is. I just

don't know that we're going to deal with it.

DR. LEWERS: Well, I'd be very willing to bag it. I'd be very willing to debate it. I think that the one instance is not one that basically the industry has set. I mean, we agree with that. But to go and say this is a physician culture, I think, is totally wrong.

I think that there are a lot of problems and it expands greatly in the fact that, you know, I remember working hard as a resident, I remember being tired, and I'm sure I made mistakes. But I also know that when I got into practice, I worked a hell of a lot harder than I did when I was in training and it was the demand of my patients who were there that wanted me there, so we go and we take this the next step forward as to the whole issue of the patient/physician relationship, the changes that are occurring at this point in time.

So I would love to see the debate of that. I think that the point you make is a single incident. I would not take that to the statement that's put here.

DR. ROWE: If I can join this a little bit, Gail. I think as one of the members that didn't criticize Dave

Blumenthal, since he was one of my former students and colleagues, I think you're right. I don't want to be operated on or anesthetized by somebody who hasn't slept in 48 hours, and I don't want a person reading my EKG if I'm in the emergency room having chest pain if there's a similarly trained, competent, better rested person available.

I think what we're hearing here and what we're reading here is an increasing distant between where the field actually is right now, the leading edges of the field, and where the regulators seem to be.

There's a lot of information and excitement about reducing errors. The joint commission's approach has changed, the AMA is pushing, the AHA is pushing, we're all working. One of the institutional goals at my institution is to provide safe, ever-free medicine. That's one of the four or five institutional goals. That didn't used to be.

We're all working there; yet, we come here and recommendation number two, dropping out a couple words says, the Secretary should consider opportunities for addressing error in conditions of participation in health care providers. So we're getting the regulatory nuclear bomb

threats and the field is trying to get to a different approach.

What I'm feeling here is the friction and the gap between those two. I don't think anybody feels that they'd rather be treated by a fatigued doctor and I don't think, with a few exceptions, that most leaders in medicine today have this machismo view that unless you're up all night every other night for ten years you can't be a good neurosurgeon.

But I do think that this doesn't quite reflect where the field really is.

DR. MYERS: No, it doesn't reflect where the field really is, but I'd like to point something out to my friends and colleagues around the table. Ted and Bill would never associate or never refer patients to people that they felt were of bad quality. In fact, I doubt if they know many people that are in that category.

Jack's institution is at least one perhaps two standard deviations away from average in just about everything you could possibly think of, as well it should be. The problem is that there are a whole lot of

institutions and providers that are on the other end of the scale that we must acknowledge are there and we must do something about.

Everybody at this table is working actively, is working very hard on these problems, knows a lot about them, and has a good strong sense of where we should head and where the field is, and I understand the resentment, the indignation, and the other emotions that are expressed with respect to having yet another mandate, yet another regulatory effort, yet another assault on the profession.

On the other hand, there are a lot of providers out there that are within a couple of miles of Jack's institution, irrespective of how long they had been up, where you wouldn't necessarily go or refer anybody to go and they are practicing medicine, duly licensed by the State of New York today.

I'm not picking on New York. They're all around. We have to go at this problem differently than we've gone at it in the past.

DR. CURRERI: Are you suggesting that we go after them proactively in a non-penalty form or are you suggesting

we --

DR. MYERS: No, I'm not trying to design the program today and I don't know that we are going to be able to have the kind of discussion necessary to put all the parameters in, and yes, I believe there's a range of responses with respect to consequences, as I said earlier, and I'm not advocating any specific set of consequences.

What I'm advocating is that we take the step, that we move forward with this, that we acknowledge that it's an issue and we use our voice on this Commission to make a strong, positive, public statement that we must do better.

DR. CURRERI: Essentially you're supporting recommendation number one, and I can support that 100 percent, as I started my response with, because I participated in that and it works. There's no question about it.

DR. MYERS: I would conclude by saying that all of you who are having difficulties with those products that you bought a few years ago, we'd be happy to talk to you about a '99 model at your earliest convenience.

DR. LEWERS: Woody, I don't disagree with you,

including letting me buy a '99 at cost. And you know my feeling, your vehicle saved my life. But I don't disagree that we need to take a step forward, but we've got to take the right step forward.

I think programs like the National Patient Safety Foundation, the VA program, the AMAP program, these are all step forwards. Let's move forward with those, but not in a statement saying we've got a culture which is directed by physicians to go quite the opposite.

DR. MYERS: Let's get Dave's paper because I want to see the whole context in which that quote was made.

DR. CURRERI: I'm not even sure he said that. It says one commentator, so it may not have been him.

MS. DOCTEUR: No, it was a comment from David Blumenthal. It's a JAMA article. I'll send it on.

DR. ROWE: But he's not on the Commission and we are, so let's not worry about Dave. Let's worry about what we think is the right thing to do because I'm not trying to say all doctors are great and I'm not trying to say that there aren't doctors and places out there that are making errors and doing nothing about them other than maybe hiding

them and we shouldn't do anything about it.

What I am sure of, though, is if you put a rule in there that if you ever make an error you go out of business, I can tell you the OIG is much more interested in putting Johns Hopkins, Penn, Mount Sinai, Cornell, Columbia, and Harvard out of business than they are of some little community hospital out of business.

So that would be what would happen. And so, I think we have to realize what we're dealing with, what the implications are of what we're dealing with here.

DR. WILENSKY: Continue on. We still have other areas.

MS. DOCTEUR: Now that we're done with the non-controversial part of the paper, let's move on to autopsies. Briefly, the draft chapter concludes that autopsies can yield multiple benefits for public health, medical research, quality improvement. They can be used to identify health care errors and to learn from them.

We believe that hospital autopsy use is suboptimal. Most experts who have looked at the issue tell us that we're not doing enough autopsies and it's a concern

that we keep doing less. One of the problems is that we don't know what the optimal rate is. The current rate averages 10 to 20 percent, with some hospitals at virtually zero percent.

Information from autopsies is not used as well as it might be. We know there are problems with collecting the data in a standardized way, making sure that the data get turned into information and the right kind of information that can be used to benefit doctors and patients.

Hospital autopsy rates continue to decline from a rate of about 50 percent in the 1960s to where we are today, and there is pretty clear information that the primary reasons for this decline are the lack of direct reimbursement by Medicare and -- lack of direct reimbursement by Medicare and lack of reimbursement by other payers; our retraction of minimum autopsy rate standards that were set by JCAHO and Medicare in the past that have been since retracted.

These are considered to be the two leading reasons. Other reasons include the malpractice litigation concerns, although that's disputed, and the disputed belief

that diagnostic advancements reduce need for autopsies.

Continuing, some more conclusions include that beneficiaries should benefit from improved autopsy use, although any efforts to improve autopsies will have sort of a public goods aspect in that we expect that there will be greater improvements in health care quality overall.

Beneficiaries do represent about three-quarters of hospital deaths, so this is a big issue for Medicare. Medicare's policies might strengthen autopsy use. Four avenues are discussed in the paper. First, conditions of participation. I want to note that the paper stresses that there's more than one way to change conditions of participation, not necessarily just changing rates and setting rates in stone.

Other options include things like changing -- requiring hospitals to make this a focus, for example, of quality improvement, requiring them to do things like setting up offices of decedent affairs that do certain things. So we don't necessarily need to think about this in terms of just rates, and the paper tries to lay out reasons why rates have been seen as problematic and reasons why

rates have been proposed.

Payment is a second issue. The paper notes that many of the outside groups that have looked at this issue have told us that the payment is a primary problem. If we just change conditions of participation, we will not be successful. Without reimbursing for autopsies in some way that's more direct than what we do now, we're not going to see a change.

The paper outlines a few ways in which we might think about going about changing payment, one of which being adding autopsies to the Part B physician fee schedule, and the paper tries to describe some of the pros and cons of doing it that way. There's also some other ways to think about doing this like adding performance incentives to hospital payments, and that's something else that could be pursued, and there are probably some other ways that aren't discussed in the paper.

The other two avenues that are discussed in the paper include making autopsy a quality improvement focus. This would involve bringing the quality improvement organizations on-board to make this a special projects

issue, or possibly including some type of autopsy measures in performance measurement that's geared toward hospitals.

Moving on to the recommendations, there are two proposed recommendations. First, that Medicare's policies, including payment and hospital participation requirements, should promote appropriate use of autopsies. I need to point out that the recommendation takes a middle ground in that it says that we should make these changes, but at this point, it doesn't specify how.

So I'm turning to you to say, if you want these recommendations to be there, do you want them to leave them at this level, do you want to try to be more specific, or do you want to not have this recommendation.

Second, Medicare should promote use of information derived from autopsies in quality improvement and error reduction initiatives. The paper suggests a few ways in which this might be done, primarily through trying to encourage the industry and the medical profession to make this a priority and to develop some secondary level incentives on that part. So I'll turn it back to you.

DR. WILENSKY: Let me, before I open, just ask a

question which was not contained in the information and I would guess it's not available. When I was reading the material and when I saw the recommendation referring to appropriate rates of autopsy, it seemed to me that this was fundamentally a sampling question.

All of the discussion treated it as, you know, it used to be this number, it's now this number, this sounds low, but without the kind of information that perhaps a biostatistician may be able to help us with in the sense of given certain kinds of outcomes or certain kinds of disease classification outcome combinations, something of that, what would be appropriate sampling rates that would be relevant for autopsies used.

I don't know whether those kinds of numbers are there. Otherwise, it's just like, well, this isn't a real high number and now we're at a lower number.

MS. DOCTEUR: That's a key issue and there is at least one paragraph in the chapter that tries to make the case that one of the most important issues is that we can't specify any rates objectively at this point because there are some practice guidelines that say, you know, under

neonatal deaths, under obstetric deaths, certain deaths we should definitely do autopsies, but those practice guidelines haven't been studied to determine the extent to which the practice guidelines kind of --

DR. WILENSKY: Let me just take it one step further and then I'll open it up for questions. My guess, and it is no more than my guess, is that those were not done within the framework of a sampling statistician's mind. They were done at this is a really bad outcome, and therefore we ought to look at 100 percent, which is never statistically necessary depending on the university.

Rarely do you need, for purposes of making a reasoned judgment, would you need to have a complete sample, 100 percent sample. So what I don't know is even in those instances, was the decision made on the basis of the kind of sample it would take in order to make an informed judgment about whether this was a problem, or was this basically an emotional response to a very bad outcome and therefore we want to send a signal of what a bad outcome it was so we have 100 percent sampling rate.

You may not know, but maybe in the next round, you

could look at that question, because when I got done with it, I just felt very uneasy that I didn't really know -- I didn't have a good sense of what would a reasonable rate be, differentiated however, and then we can talk about how might we get there, who has to pay, blah, blah, blah.

DR. CURRERI: I thought a lot about this because when I was a resident and intern in the early 1960s, I can remember our autopsy rate was always over 60 percent and we took great pride in that. In most hospitals, I think that 10 or 15 percent autopsy rate is very generous today.

I might add that in the early '60s when the autopsy rate was that high, there wasn't any payment to pathologists for doing autopsies then either. They were paid by their institutions and this was thought by the institutions to be very valuable in terms of maintaining quality and improving quality.

Thus, I really don't think that directly paying pathologists is a very strong incentive for increasing autopsy rates. That's number one.

Number two, I suspect that pathologists can make a whole lot of more money faster supervising laboratory

results than they can doing autopsies, for sure. But let me say that I think that you missed -- and this is purely anecdotal, but it's my observation over about 40 years now of why we're seeing this decreased autopsy rate.

I really relate it to the widespread distancing of families with transportation needs so that residences of children and others close to whoever the decedent is live fairly far away.

In the 1960s, most people lived within 100 miles of their parents, the vast majority, and when they got ill or were seriously ill, the family came in to see them, they talked to you and I talked to them, and when the patient died, perhaps two or three months later, the family knew me intimately and when I would ask for an autopsy, they felt in many ways that they owed that and they were comfortable because they had been there with their loved ones during the deaths.

Today the normal experience is that you call the family and tell them they're seriously ill and they say, is it an emergency, because they live 2,000 miles away, and you say no, but they're seriously ill, and then they say, well,

call me if things really look bad.

They fly in two or three days before the patient dies. They don't really know you, they haven't talked to you. They certainly aren't going to talk to their loved ones about an autopsy. In case those in the audience don't know, when you die, you don't own your body anymore. Your next of kin owns it and only the next of kin can give permission for an autopsy.

There's an enormous amount of guilt on the part of these family members, perhaps unjustified, but they feel guilty that they weren't there during this last illness and that they perhaps didn't have as close a relationship as they should have.

So when you get to asking for an autopsy now, they say, oh, no, mom or dad can't suffer anymore, and that's really the cause for the decrease in autopsy rates. I don't present it to the family any different than I did 40 years ago, but the response is entirely different and I really have related this to the non-closeness of the family during a terminal illness more than any other factor.

DR. LONG: I just wanted to reiterate Gail's

point. That's exactly how I came away from this, with total incredulity that there is no one thinking about this in terms of statistical terms. We use the language, seemingly suboptimal. I don't see anything that tells us, in terms of generating information to reduce errors, that we have any information to whether it's optimal, suboptimal, superoptimal.

Clearly you don't take 100 percent censuses in order to determine the characteristics of populations. Maybe a 5 percent sample is loads. It's clearly potentially different depending on how you stratify the population for the different characteristics you're looking at.

I'm neither a pathologist nor a statistician, but surely there's some biostatisticians out there some place who must have looked at this question at some point in time to ascertain what kind of sampling rates are necessary for generating the kind of information that seems to be the major thrust of this chapter.

Now, I appreciate that there are other reasons for doing autopsies as, for example, training pathologists and that may create a higher requirement for autopsies than

simply the information that would help us reduce errors. But I'm really bothered by the fact that we seem to have no statistical basis for the judgmental comments that are being made in the chapter.

DR. LEWERS: I think that we'll hear, and I'm anxious to hear the comments from the public section, but I think there are a couple areas I'd just like to comment on and one is in the first recommendation where we say including payment and hospital participation requirements.

I think we probably need both of those. I don't think you can put a requirement if you don't have some way of reimbursing it. Reimbursing systems have changed and changed dramatically since Bill Curreri and I were out learning how to do autopsies and how to evaluate them.

So we've got to take that into consideration. It is an element. At some point somebody is going to have to pay for it, whether it's the hospital or whether it is the physician.

I think another critical area which I see missing in the paper and that is the patient/physician relationship erosion. For instance, in many areas today, we have

hospitalists, first time the patient coming into the hospital sees that hospitalist is when they walk in the door and sometimes you don't even know when you walk in the door that you're going to see that individual or even who that individual is.

So for that individual to walk up to a family that has never met the individual, never seen the individual, and have that individual have trust or the family having trust in that individual to say that when they come in at a very difficult time in life and that is when a loved one dies to ask for an autopsy has got to be playing a role.

I think another role which I'd be interested in hearing on the comment and that is the education of our physicians today. We think we do MRIs, we do PET scans, we do CT scans, therefore we know everything that is inside of that body and we don't, but that's the concept that you will hear when you talk to many of the physicians in training.

We don't really need it because I already have looked at that and so, I think we've got to -- I'd like to see some comment on that in the paper. I think those are critical areas.

DR. LAVE: I am going to start off with a statement, which is that I find the whole autopsy issue very puzzling. Partly, I think, and I'm trying to read this, as I told Jack and other people, that I don't really understand this desire to increase the number of autopsies and I've tried to.

I guess it's because some of us bring preconceived ideas to the table. Now, my preconceived idea is that the reason that you had autopsy was that somebody died and you didn't know why they died and you wanted to figure out what was going on. So they died under suspicious circumstances and you wanted to understand something related to that death.

Now, the reason that I say this is -- and I wasn't going to comment on this section -- was that if somebody came up to me and said to me, when my mother had died, would I agree to have an autopsy, I can't figure out why I would want to agree to that.

I mean, they'd have to tell me why. She's an old woman, she's 93 years old, she's dying sometime, in the next two to three years or so, but when she dies, my feeling is

her time will have come. She's going to die of lots of different things. I don't care whether or not they sort whether it's A or it's B, so it's not good to her.

I would have to be convinced by you about why you would need to do this. I haven't seen anything here that would do that. I don't know whether or not there would be errors. I don't know whether or not, in fact, if there was a minor error in the treatment of her case it would make much difference.

So I'm kind of very confused about the whole autopsy business except in cases where you kind of know that somebody has died -- if, in fact, somebody dies unexpectedly, I can then understand the purpose for an autopsy. You want to get the information. But for people who are dying and they've been dying and very sick for a long time, there's nothing here that tells me why you want the persuade the families in those cases to give permission. I mean, I've tried to lay it out as I've read it.

DR. ROWE: Judy, let me help you with that. I think the logical extension or the illogical extension of your argument is that even if they died unexpectedly, what's

the difference because they're still dead.

DR. LAVE: No, because I would want to know why.

DR. ROWE: That's interesting. But you're looking at the value of the autopsy from the point of view of what you want to know, but there's a contribution to medical knowledge, there's a contribution to the training of physicians, to our understanding of disease.

You know, back in the Korean conflict, autopsies were done on a whole bunch of soldiers I think who were killed in battle. I think nobody was uncertain why they died. But we learned, I believe, from those autopsies that they had much more advanced atherosclerosis --

DR. MYERS: And Vietnam as well.

DR. ROWE: But we learned a tremendous amount about how people in their 30s, 20s and 30s and even earlier than that had atherosclerosis and it led to tremendous information about changing diet and exercise and the understanding of the development of heart disease. We thought this is something that could develop later in life.

There are advances to medical knowledge that are very important. Then the next logical question, I think you

have, about your mother who's in her tenth decade of life in Canada and doing fabulously, I hope, is well, she's so old, what's the difference.

Well, I can tell you that we're talking about Medicare beneficiaries here. There are more old people than there used to be and doing autopsies on suddenly dead neonates is not going to help us a lot in understanding what the medical problems of very old people are. We have to study the people who we want to help.

DR. LAVE: Then if you want to be Bill's person, then you have to --

DR. ROWE: I'll be his person any day of the week.

DR. LAVE: No, no. I wonder if Bill is going to come and talk to me. It seems to me that the issue then is that what you need to do is to develop a statement that is handed out to everybody -- forget about the right number -- who goes into a hospital and says, we are going to ask some proportion of you for this for these reasons. But you have to have a convincing reason, it seems to me, and you might -- we're going to get there.

DR. ROWE: You want to talk to the patient.

They're coming in. You're going to have a routine --

DR. CURRERI: I think to answer your question, I really believe that you have a very good point. For the person with chronic disease and that chronic disease has progressed until the patient is 105 and then the patient dies, we probably wouldn't learn. But what you're really learning, what you really want to know from that 93-year-old or the 95-year-old that dies is, was there an error in diagnosis. Have we been treating them for 20 years for the wrong disease.

DR. LAVE: Pretty successful, I would say.

DR. ROWE: You're going to be old someday yourself, if you're lucky.

DR. CURRERI: Or has there been an error in treatment in which the wrong treatment was given and it may be both things. It's the wrong treatment given for the wrong disease.

DR. LAVE: Let me ask you --

DR. CURRERI: There are a lot of things --

DR. LAVE: It's primarily an information issue?

DR. CURRERI: Sure, but it's a teaching

instrument. There are a lot of things to learn from your mother. Why doesn't she have Alzheimer's disease, what makes her different from the person that had 20 years of non-functional life with Alzheimer's disease. Those are the things we can learn about from doing autopsies. So I think there are good reasons.

DR. MYERS: Very short. My medical upbringing was similar to Bill's. I asked for a number of autopsies and I can remember learning a great deal from those, a number of them specifically. And personalizing it, Judy, both of my parents have passed, both of them had autopsies, both of them had unexpected findings that were very important to know about.

I can't say it any better than as follows. You don't know what you don't know. Unless you have an opportunity to learn, you can't say what you don't know and an autopsy surprises you more often than you would suspect with information, with knowledge that can be beneficial to other patients.

So I would wonder, on our second recommendation, whether Medicare should limit its promotion of information

used just to those areas and whether or not there should be a component somehow related to informing the beneficiary about the values in a sensitive and in an appropriate way of the procedure.

DR. WILENSKY: I think that this issue of the appropriate sampling rates, or something about the range of appropriate sampling rates, even given the understanding that it's hard. When you don't know what you don't know, it's hard to set an appropriate sampling rate. This is something that if you're going to be convincing, it is not just here are the kinds of information that only can be provided after the fact from autopsy, but some reason why these numbers are important as part of a package.

I have not seen -- it may be that it's out there. I have not seen it framed that way and it troubles me.

DR. CURRERI: Just to comment on Woody, it's not only the beneficiaries, but it's whoever the next of kin is because they're the ones that make the decision. I find most beneficiaries don't broach the subject or talk to their families about it because it's too threatening to them.

MR. MacBAIN: To go back to where we started with

Gail's comment about the sampling rate though, I think the argument is convincing as far as it goes that autopsies are a wonderful source of very beneficial information, but if we don't know that we have sampled a statistically significant share of the population, we don't know if we know anything when we're done.

We don't know if what we have got is really knowledge or whether it's just a collection of interesting, independent anecdotes. The study of war dead presumably was a large enough sample that there was a sense that this was a statistically significant share of the 17 to 22-year-olds and that we could draw inferences from those who weren't dead.

That may be less true for autopsies done in a number of community hospitals around the country where the sample size seems to be random and where it's not clear what happens to the information. So I think that needs to be added, that this argument becomes a lot stronger if it's in the context of statistically significant samples, publishable data, that it's more than just one anecdote after another.

DR. ROWE: I think there's also the question of how many autopsies a pathologist needs to do in order to be fully trained. You know, surgeons, I think, still are required to do -- if you're going to be a general surgeon, you have to do so many gall bladders and so many colons and so many stomachs and so many whatever, you know, depending.

I mean, there is this issue there. There is a national need for a cadre of expert professional anatomic pathologists. I don't know what that number is, but maybe somebody does, and they need to do X number of autopsies to get trained. So there is that, also, in addition to the sampling number. There's another frame into which we have to look to see.

Now, the sampling number might come up to be a number that's higher or lower than the training number, but it's a number.

DR. CURRERI: I think also you have to make a decision whether you have to oversample in certain areas for diseases we don't -- for geriatric diseases we don't understand, you might want to oversample that area, for instance, Alzheimer's disease.

MR. MacBAIN: The point is to recast this argument as an academic pursuit of knowledge.

DR. LAVE: I have a question. This is something that I obviously don't know anything about, but let me ask you the question. As I listen to you now, what I hear you now talking about is sort of really training purposes, knowledge purposes, understanding diseases. If I have a 100-bed hospital and I increase the autopsy rate to 40 percent, I won't have that many.

Would I be achieving those purposes in those hospitals? We're talking about non-academic hospitals where people, in fact, are not studying the nature of the disease. Is there a difference in the type of institutions where we want to get these rates up?

DR. WILENSKY: I would like to open this discussion up now, but I think that we need, to the extent that we have different objectives or different goals, that we're thinking of using autopsy as an error reduction would suggest a rate that might not be suggested as a way of furthering information about the progression or appropriate treatment or diagnosis of particular diseases.

I do think approaching the issue on these terms is a more satisfying rationale as to why for certain types of hospitals, certain types of patients, these are the kinds of rates that would be regarded as appropriate.

My guess is that the training needs are far below anything that we're talking about, but that's also an issue.

DR. LAVE: Can I ask another question that has to do with errors, if we're focusing on errors?

DR. WILENSKY: I just raised it. I just think that to the extent that you have several goals that may suggest that you have different numbers in order to meet each of these goals, and that means for some institutions it will be a higher rate and for some institutions a lower rate.

DR. LAVE: Well, the other thing has to do with the selection of people who you autopsy, right? If it turns out that you're looking for errors, would you do a random sample of all patients or would you do a random sample of certain patients for whom there may be a higher probability than an error actually took place. So is it a specific --

DR. WILENSKY: I don't think this is the group

that's going to answer that kind of question, but this, it seems to me, is within the general framework that in justifying or arguing for specific rates, you need to talk about what it is you're looking for, therefore what it is you're trying to sample.

If you're trying to find out what we didn't know was out there, that's going to be a different kind of a sampling strategy. If you're worried about trying to come up with whether or not you had the right diagnosis or the right treatment given diagnosis, I mean, those will obviously give you different rates.

Let me, before we do any final decisions on these recommendations, open it up for public comments. Our inclination at the moment is the following for the rest of our schedule. We are going to do the middle discussion tomorrow unless there's some request. Otherwise, we've let Beth have the whole morning and I think that's probably enough time for any one individual. We'll continue with the afternoon's discussion and then come back tomorrow and pick up the middle discussion. Public comments, please.

DR. ROWE: The middle

DR. WILENSKY: The quality and traditional fee-for-service we'll leave for tomorrow. Identify yourself, go to the mike, and keep your comments brief, please.

MR. CASEY: My name is Dr. Don Casey from the Maryland PRO. I just want to raise two issues with respect to autopsies. One is that I think focusing on the demand side is, in my mind, where the money is because I think that people have changed their attitudes about that.

The second thing is, there really are two concepts buried in the autopsy and one is a forensic approach and the other is a clinical information approach, and while those two overlap, I think they're distinct, and I believe that the paradigm with which this is being presented is really weighing more in on the forensic side of this.

So I think it would help the Commission to think about those two as separate issues. You can read the case studies of the Mass General every week in New England Journal and they're wonderful educational tools, but their not forensically motivated. So I think that helps.

MR. WOOD: I'm Thomas P. Wood, the president of the College of American Pathologists, and on behalf of the

college, I want to thank the Commission for allowing me to be here today. I will certainly try to keep my remarks brief.

I will say first of all, though, that I've been tremendously pleased with the discussion that I've heard, the questions that have been asked, and the comments, and I'm very much encouraged about the activities of this Commission.

I'm a pathologist who practices in Tallahassee, Florida and I practice anatomic and clinical pathology and I've performed several thousand hospital and forensic autopsies. Autopsies have been a big part of my professional practice.

I'll digress just a minute to tell you that I did an internship and a residency and then was a family practitioner for six years before I went into pathology. I drive a Ford Bronco that's 11 years old. I went to Tulane University School of Medicine. I've been a member of the AMA ever since 1957, and I find a great deal of commonality with many of you. So I feel very comfortable here.

DR. ROWE: And this isn't a bipartisan commission

so we don't need 11 votes here.

MR. WOOD: I think that we've heard a lot about the immediate value of autopsy to the practice of medicine as a resource for assessing the quality of care. But there's a broader value and I think you've touched on that. Remember that there are new diseases that have been elucidated primarily through the autopsy. Toxic shock syndrome, Legionnaire's disease, sudden infant death syndrome, and acquire immunodeficiency syndrome are examples of the contribution of the autopsy to the understanding of new diseases.

There are many causes for the decline in autopsy rates, and some folks tend to criticize the joint commission because of the reduction of the rate requirement. But there's much concern among pathologists and hospitals that the autopsy lacks the professional rewards and the compensation that it deserves.

Now, we pathologists have not reached consensus on how best to assure that autopsies are performed in sufficient number to achieve the goal of benefitting medical practice, the public health, and the families of the

deceased. Complex economic, medical, and emotional issues are involved.

Simply establishing numerical requirements for autopsies is not the appropriate answer to the problem. An absolute requirement to meet a quantitative autopsy goal is not feasible in this environment of scarce resources and cost containment.

The college believes that the autopsy's potential for benefitting the health care system will not be achieved until appropriate financing of autopsy is addressed. Generalized underfunding of the autopsy has meant that many hospitals do not provide state-of-the-art facilities and technology for the autopsy.

Many autopsies do not have adequate environmental engineering to protect staff from pathogens. Little attention has been given to the use of new technologies to enhance autopsy examination.

Now, if there's going to be a rejuvenation of the autopsy, we must begin by looking at how to appropriately pay for the service. Hospitals and pathologists must be adequately compensated if quality autopsy services are to be

available.

Now, we will be glad to work with the Commission and the Secretary of Health and Human Services to develop equitable payment policy for the autopsy. We, as an organization, the College of American Pathologists, have also been actively involved in developing practice guidelines for autopsy performance and reporting, and we've already shared much of this information with the Commission staff and we'll be happy to work with you and others to improve the collection and the utilization of autopsy data.

Now, in response to some of the discussion that has just been held, I do want to say that -- and Dr. Wilensky brought this out -- rigid rules and sampling rules are difficult to apply, and I also totally agree with the comments that have been made. You don't learn if you don't look and you don't know what you're going to find until you do look.

So there is an almost serendipitous benefit of the autopsy that I have seen over and over and over again through my years of practice. I also strongly agree with what's been said. The autopsy is not a problem as far as

malpractice is concerned. I have found that the autopsy has prevented malpractice litigation, in my experience, through thousands of cases more than it's led to it.

I think that -- incidentally, the college has criteria listing those categories of death or those cases in which the hospital pathologist should seek permission to do the autopsy. Remember, autopsies, except forensic autopsies, are not done without permission of the family. There has been practically no education of training physicians or medical students or residents in the various specialties as to how to go about getting autopsy permission.

It's been sadly neglected for years. So that is certainly something that needs to be -- I have gotten telephone permission for autopsy in many, many cases when the family couldn't be there, and there are statutory opportunities that allow for the autopsy to be done when you cannot get family permission. But nevertheless, the reasons for why they're not done are really very complex.

We really do need to work on this question of how many, and how many varies from institution to institution,

from patient population to patient population, from medical staff to medical staff, and there's got to be some random sampling, but we don't want to incur such a burden that we cannot either fund it or perform it physically.

I will close, and I don't intend to be funny when I say this. I used to be sort of tried to be funny with it, but I've said for years that the autopsy is the last real bargain in health care. It's such a good bargain that it's just about driven itself out of business. But nevertheless, I speak in favor of more autopsies and certainly more and better funding and I thank you very much for the opportunity to speak.

MR. LUNDBERG: Dr. Wilensky, Dr. Newhouse, members of the Commission. I was going to say good morning, but I guess I'll say good afternoon. I'm Dr. George Lundberg, editor and chief of Medscape, the leading health information cite on the Internet. That's Medscape.com. Check it out this afternoon.

I'm also a professor at Harvard and at Northwestern and today I speak on behalf of the American Society of Clinical Pathologists of which I am a former

president. I appreciate the opportunity to address the commission on the subject of patient safety and specifically the autopsy.

I want to say how gratified I feel at having heard this discussion of a very, very complicated set of problems, error in medicine and the autopsy. When I first received Lucian Leap's paper called Error in Medicine and it went through -- it was in an earlier life when I was at JAMA -- and it went through review and revision and review and revision, I almost didn't publish it because I was scared to publish it.

I figured I'd get canned the next day after it was published by my employer. I wasn't. I worked five more years, but that paper, the AMA responded to by creating the National Patient Safety Foundation, not by trying to hide error in medicine, which I think was a wonderful response.

I consider the autopsy a metaphor for quality, an irreplaceable prism through which a person or a society can view life by studying death. The official statement of the ASCP has been provided to you and I've passed out another statement and we've been given a lot of information this

morning as well.

These documents speak from science, fact, and intellectualism, in other words, from the head, but I will speak from the heart as a long-time member of the medical profession of the American Medical Association, as a pathologist, and as a patient interested in my own care.

For me, this presentation all began at the autopsy table, the place where real doctors, Judy Lave, where real doctors learn to distinguish truth from fiction, to reconcile image and reality, and to recognize from their own experiences that throughout this century, including the 1990s, the rate of significant discordance, meaning disagreement between major diagnoses, premortem and postmortem, remains about 40 percent of deaths when patients are autopsied. You don't know when they are.

For me, it all began at New Hill Burton Hospital in Tuscaloosa, Alabama in 1953 when a young girl having an unnecessary but then commonplace surgical procedure called tonsillectomy and adenoidectomy died unexpectedly in the recovery room.

The caring surgeon and the caring pathologist

autopsied the child. They found that her respiratory tract was filled with fresh blood from the operative wound in the throat. She suffocated in her own blood. Events such as this cause a reappraisal of the operation T&A and an eventual vast scaleback of its frequency.

It also taught me, the premed college student working in a lab, the value of autopsy in assessing and assuring the quality of medical care and preventing error and assuring patient safety.

You the members of MedPAC now have a unique opportunity to help to rescue this metaphor for quality of care, the autopsy, from virtual extinction. Seventy to 75 percent of all people dying in this country are Medicare beneficiaries. You, thus, hold all the keys to at least the beginning part of the power to succeed or fail in rescuing this resource.

You can choose again to validate the mass delusion of premortem clinical omniscience that is widespread. Such a decision would be very popular with many, an easy out for you, where you can recognize a critical reality of science and follow the insightful and courageous lead of Dr. Ken

Kizer, the under-secretary for the Veteran's Health Administration, who sees the issue clearly and has, on February 26th, 1999, issued VHA Directive 99-104, "The Autopsy as a Critical Element of Quality Management."

You can set into place the beginnings of a method to right this 30-year wrong of performing few or no autopsies in so many hospitals on Medicare patients, and you can do it without costing U.S. taxpayers a nickel, by dictum or by incentive.

I have appealed personally and privately over the years to a series of administrators of HCFA to right this wrong. Caroline Davis, Bill Roper, Gail Wilensky, Bruce Vladeck, and Nancy-Ann Min DeParle all have been courteous and all have expressed sympathy for my point of view.

In the early to mid-1980s, Caroline Davis, in Rome as a matter of fact, assured me that the autopsy would not be harmed by moving from cost reimbursement to prospective payment. She said the autopsy money was being built into the DRG. It's always been there. It's there today. The Medicare beneficiary in the United States has the right to a prepaid autopsy, every such beneficiary who dies, and they

all will.

But that money is invisible, especially to those many who don't want to find it in the DRG, and I've asked each HCFA administrator to make a line item for autopsy payments so it's not invisible and where everybody pretends it ain't there.

Bill Roper, as an epidemiologist, agreed that there should be randomization of autopsy selection for detection of medical error, perhaps 10 percent, on top of the 20 to 30 percent of clearly clinically indicated autopsies.

Lee Goldman, the one clinician in America who knows the most about this than anybody when he was still at the Brigham & Women's, agreed with this idea, a 10 percent random over the 20 to 30 percent indicated. But for one reason or another, more pressing needs, lack of an organization, powerful pro-autopsy movement or time running out, denial by HCFA continued unabated.

An uncounted tens of thousands of diagnostic and therapeutic medical errors in Medicare patients went with the patients to their graves undetected and uncorrected.

But this is a new day. A new century is almost upon us. The AMA has created the National Patient Safety Foundation. Prevention of medical error is now in vogue and is becoming politically powerful.

Truth telling, truth finding, openness in disclosure, systems changes to prevent error without pointing fingers at people, honesty with patients in the public are now popular, even essential. You cannot prevent repeated errors if you don't recognize them in the first place.

For years, I've asked the quality gurus this question: How does one evaluate the quality of care given to the sickest patients, the ones who die? You have to start with the A word, autopsy, or the ball game is over before it even began. You can help make this happen. I hope you will. I'll be watching.

DR. WILENSKY: George, would you do this as a condition of participation for hospitals or through some other mandate? Presumably, it's only going to happen if there is a requirement to satisfy certain statistical grounds or however, the 10 percent on top of the 20 percent

or whatever you were to use, but do you see this as a condition of participation issue?

DR. ROWE: The answer is no, George.

DR. WILENSKY: You don't have to give an answer now, but I think it would be helpful, in what way would we make this a requirement. I think the money supposedly is in the DRG. It was in the base that was used and it's not been taken out. Putting it as a line item isn't going to help.

MR. LUNDBERG: Somehow we're working at a culture change, a mass culture change to reverse a very ingrained 30-year culture change. When Medicare came in, pathologists started making money off clinical laboratories in all kinds of ways, especially percentage contracts.

And pathologists ran away from the autopsy to a large extent. Not all, but they said, hey, why do I want to do that? They hardly pay me anything. I want to be in a clinical lab working with live patients.

Then they had all those fancy tests, including imaging stuff that radiologists were doing which said, hey, we don't need those autopsies anymore. And sure, the modern technology is marvelous if it's used at the right place, at

the right time, and the right people, but hey, that doesn't always happen, not at all. That's why that 40 percent number just keeps hanging in there. It's amazing that it's still there.

There has to be a culture change. Discussions such as the ones you're having today are extremely helpful in the culture change. The kind of visibility we got last October, although noxious to some people, was what was necessary to create a cultural change by thinking about this issue because it does matter, because now we're looking at large numbers of doctors who are approaching middle age who came in at a time when autopsies were almost non-existent.

Large numbers of medical students who finish medical school have never even seen an autopsy. How can they value one and go ahead if they never even know where the autopsy room is. And you have managed care, which I love, but managed care hospitals being built without an autopsy suite at all. And you have a pathologist doing a research paper in JAMA in October being fired the next day by the managed care company that employed her because the data showed that autopsies were necessary.

Now, there's an extraordinary cultural gap and we're about to the end of that because those old folks sitting around the table here who don't remember autopsies, there are not a lot of us around anymore. If the data showed we didn't need them anymore, fine, let's get rid of them. But the data don't show that. Yeah, you've got to have a number.

Ken Kizer says it's 30 percent and that's what the directive says. I know the VA is not private practice, it isn't Medicare, of course not, but it's a place to start and Ken recognizes this. He put out a directive, he pulled it back, he put out another one. The one I referred to you is now real. He's putting 30 percent.

He's calling it, we shall strive to achieve. He's not saying you're going to close your hospital if you don't get it, but this is a cultural change. It's an attitude thing. It's very complicated.

DR. ROWE: I think, Gail, one of the important things -- it's obvious to everybody in the room we've just heard from two distinguished physicians. The multifactorial nature of it is so important in terms of determining the

autopsy rate that to have a kind of punitive nuclear warhead conditions of participation provision seems to me not to work. I could give you one example.

If you're a hospital in Brooklyn and you serve an orthodox Jewish community where the autopsy rates are almost zero --

DR. WILENSKY: You're not going to get 30 percent.

DR. ROWE: You're going to get whatever it is. You're going to have some HCFA administrator tell you you're not meeting the required level for conditions of participation. They're going to close the hospital and then the community loses the health care resource for some reason which is out of control of the physicians or the hospital.

Now, the absurdity of that example is, of course, no reason to think that it wouldn't happen and I think that it just sort of raises the question of how you deal with a multifactorial issue when we have influence only over some of the factors and not the others. It's very complex.

DR. WILENSKY: You could imagine a world in which there is a budget neutral redistribution of payment among physicians to cover something for Part B physicians. You

can make the claim that it's already in Part A, we're not going to do anymore.

DR. ROWE: Say it's still there, we're just going to move it around.

DR. WILENSKY: Maybe it's just something because we will deal with this chapter again in our April meeting. To the extent that there are thoughts about how to try to move toward an increased rate, either by whatever means, and I assume your response with regard to the condition of participation, I understand, but --

DR. ROWE: That's what we're discussing.

DR. WILENSKY: But the issue is how else, if people have ideas about how else to try to improve the rate, I think that would be very useful for us to have as part of the discussion. Judy and then Woody.

DR. LAVE: I wanted to ask George a question. That is you started off your statement by saying that there was a way to improve the state of the world and it wasn't going to cost Medicare any money.

MR. LUNDBERG: No, it's in the DRG. The money is already there.

DR. LAVE: Well, but on the other hand, if --

MR. LUNDBERG: Don't do so many MRIs. I mean, it's an easy trade-off.

DR. LAVE: My assumption is that you made that statement tongue-in-cheek.

MR. LUNDBERG: No.

DR. LAVE: No?

MR. LUNDBERG: Not at all. I absolutely believe the money is there. You just have to find it.

DR. LAVE: I want to follow this up. So what was your -- so if the money is already there, then your policy recommendation to improve the rate of -- what is the step that you would then take to increase the rate of autopsy, since you're telling us, I think, that Medicare doesn't have to do anymore money. They may have to rearrange it a little bit.

MR. LUNDBERG: That's correct. You need to encourage a rearrangement in the money to make the autopsy an important item in Medicare reimbursement -- not reimbursement, prospective payment. That's simple. You make it a condition of participation, and any hospital that

has more than 70 percent Orthodox Jewish population would be excepted from that, but everybody else would have to do it. That takes care of about 0.5 percent of the hospitals in America.

DR. ROWE: And all my people.

MR. LUNDBERG: And all your people, fair enough. So you have to have exceptions here and there. But when the joint commission took off the percentage, did they exist before the joint commission took off the percentage, Jack? Those hospitals were there. They met that someway. I know when I worked in the medical examiner's office at NYU or across from NYU, Orthodox Jews all the time had autopsies and they really didn't have that strong an opinion.

I would set a minimum rate. I'd make it a strive to the goal or something like that because I don't think you're going to be able to get there without being fairly heavy-handed because the culture has changed so much. And yes, the money is there and if you want to find it, I'll stay in my field laboratory testing.

Just stop doing laboratory tests that are not medically indicated by evidence-based medicine and you've

got all the money you need to pick up those autopsies.

DR. MYERS: A couple questions for either Dr. Lundberg or Dr. Wood. Would a good faith effort requirement for participation satisfy the desire and move the number up, in your opinion? Instead of requiring an actual number, requiring some kind of a documentation that there was indeed a good faith effort in a special number?

The second question, what is your feeling about regional centers as opposed to trying to ask every hospital to put a state-of-the-art facility to do it right? I mean, it's one thing to do it and another thing is to do it correctly and to get good information from it. Should we not have regional centers where these are done that are geographically accessible as opposed to every hospital trying to accomplish the goal?

MR. LUNDBERG: The last question first. I think regionalization of autopsy service is just like regionalization of any other. Technically demanding, skilled requiring service in American medicine is a logical thing to do and there hasn't been much push for it because you have to get people to cooperate to do that.

But then you lose the advantage of the doctor who took care of the patient seeing the autopsy. I mean, that's where the main continuing education happens in the 100-bed hospital that gets the 40 percent autopsy rate. If the doctor who took care of the patient shows up, that's CME big-time, big-time CME that occurs right there.

If the doctor doesn't go to see the autopsy, they can still learn from it, but not as likely. In addition to that, the VA has said, and I totally support this, that a well-done autopsy should be done relatively soon. The reports should be made available to the family and a physician, the pathologist, or the other physicians should sit down with the family and talk about the autopsy as quickly as they can.

They say you can do that in 72 hours. In that way, if there's a problem, you find it, you disclose it, you discuss it, you educate, you understand, you fix things. That's the whole national patient safety movement.

Now back to your first part. If you just say, this is important, because nobody said it's important except a few voices crying in the wilderness for the last 30 years.

Just say, this is important, let's start moving it back. If the joint says that, the VA has said it. They said 30 percent. If this committee says it, if various other kinds of medical journals say it, and if public media commentators say it, we'll move the culture back. That's what we're trying to do. I see that as huge progress.

MR. WOOD: I would like to respond as well. In response to your second question first regarding regionalization, I think there's a great future for regionalization, but just as Dr. Lundberg said, you can't remove it so far away from the patient and the physician that you don't get the benefit from it.

However, with telepathology and some of our modern communication methods, we may be able to get around some of that, but there is definitely a place for that. Furthermore, in spite of a comment that was made earlier from the floor, there is a combination of forensic pathology, autopsy practice, and hospital autopsy practices that can function and I see that occurring more and more across the country.

As a matter of fact, I'm a senior member of a 13-

member group. We started with three. We always did autopsies because if we were going to be the pathologist community, we did everything that needed to be done, not just because -- we didn't refuse it because we were poorly paid. We felt an obligation to do the community pathology. We became medical examiners and I served as medical examiner for 15 years for a community that has ten counties, ordinarily seven counties.

So I've combined the hospital autopsy practice, a hospital of 650 to 700 beds, plus another hospital of 120 to 140 beds, plus some little hospitals in the countryside, I have combined that with the forensic pathology operation and it has functioned very effectively. So there is an opportunity to do that.

Back to the first question. Refresh my memory. What was the first question again?

DR. MYERS: Whether a good faith effort requirement --

MR. WOOD: A good faith effort should be satisfactory and we in the College of American Pathologists have a great deal of concern about a rigid percentage that's

applied across the board because where you apply it varies and how you apply it should vary and we don't believe that an absolute rigid percentage is the way to go now.

Certainly if it's an unfunded mandate, that won't be catastrophic as far as I'm concerned. I do agree with what Dr. Lundberg said, though. You've got to do something to give the autopsy more importance and to encourage it. I'm a little shy, though, of a one size fits all.

DR. WILENSKY: I think we have -- again, we will have this issue on our next meeting, so we'll have a chance to see our attempt to put these sentiments into wording.

We're going to take a 45-minute break. We are obviously running late. I think this was one of our best discussions. I'm very pleased we had it, but I want to urge the commissioners to return in 45 minutes.

[Whereupon, the meeting was recessed at 1:34 p.m.. to reconvene at 2:28 p.m., this same day.]

AFTERNOON SESSION [2:28 p.m.]

DR. WILENSKY: Nancy?

MS. RAY: Thank you, good afternoon. I'd like to talk to you about the issue of access to care in general and use of primary care services in particular, and our results from a quantitative analysis that we plan on including in the June report.

As you are aware, the Medicare program has been successful in reducing access inequities among its beneficiaries. However, as reported by MedPAC, PPRC, and lots of other researchers, certain vulnerable populations get fewer needed preventive services.

Many factors have been found to affect access to and use of health care services, patient demographics, income, education. Some of these characteristics are changeable and some aren't. For example, PPRC previously looked into several variables including age, race, place of residence, income, and reported differential use of health care services.

The simple existence of a clinic across the street is not necessarily sufficient to ensure that beneficiaries

are obtaining needed primary care services. The goal of this analysis is to examine the extent to which patients' behavior, their perception of the health care system, and their perception of their physician, their provider, how that affects their use of primary care services.

In addition, the goal of this analysis is to review the extent to which possible interventions such as patient education can change patient perceptions.

We are in the process of conducting this quantitative study for all Medicare beneficiaries as well as for Medicare beneficiaries with diabetes, and right now I'd like to present to you the initial results of the analysis of the beneficiaries with diabetes.

At the April meeting, I will hopefully have final results as well as recommendations for the commission to comment upon.

Well, as we're all aware, diabetes is a complex, serious, and costly disease. I could probably talk at least a good 30 minutes on that. It's very prevalent among the over-65 group. It represents nearly half of all persons with known diagnosed diabetes. In 1997, the ADA, using

research that I did, published that direct medical attributable costs among persons in this age group were $27 billion. That's a lot of money.

And that aged persons with diabetes costs 1.6 times more than their non-diabetic counterparts. Access to and continuity of medical care in the management of diabetes is critical, and as a result, the BBA, in 1997, expanded payment for outpatient diabetes self-management training services.

Specifically, the BBA extended payment in the first year for up to ten hours of an initial outpatient diabetes self-management training; in subsequent years, a one-hour single session follow-up. This provision is limited to beneficiaries who are new onset or poor glycemia control, or at high risk for microvascular complications, including renal, eye, and neurologic.

Previously Medicare only covered patient education through outpatient hospital-based programs. The question -- a couple questions come to mind with this expanded payment, the first being, well, what effect will the provision of these patient education services have on the use of

preventive care services, and rates of hospital admission among beneficiaries with diabetes.

Secondly, should similar benefits be considered for beneficiaries with other chronic and serious diseases? Third, to what extent should Medicare be considering other disease management interventions? And fourth, to what extent do patient health care beliefs and perceptions influence the use of preventive care services. If you believe that education is going to work, you believe that you can change the patient's behavior.

We used data from the Medicare current beneficiary survey right now from 1994 and 1995. We identified the study population of beneficiaries with diabetes based on either a self-report, an outpatient drug claim for insulin, or an oral sulfonylurea, or a hospital admission.

We constructed a series of preventive care measures using information published by AHCPR, the ADA, IOM, and previous measures also used by PPRC. I've included in your mailing materials some of the initial results that we have for the study population. In each year we identified approximately 4 million beneficiaries with diabetes and who

met the patient selection criteria.

In terms of demographics and health, about 10 percent are 85 years or older, more were female, 17 percent are non-white. These patients have a lot of comorbid conditions. I believe it was at least 90 percent reported at least one chronic complication specific to diabetes. Hypertension was clearly the most frequently reported chronic complication.

DR. ROWE: Nancy, just to be clear in what population we're talking about, these are Medicare beneficiaries over the age of 65 plus all end-stage renal disease beneficiaries, which would include a lot of young diabetics.

MS. RAY: This includes people with diabetes. If they also have end-stage renal disease, right now they're included. But it's not diabetes plus -- it does not include somebody with ESRD unless they have diabetes.

DR. ROWE: Yes, I understand. But the point being that this is not just old people with diabetes. Since diabetes is one of the most common causes of end-stage renal disease, therefore, people should not think when they look

at these data that this is a population of diabetics over the age of 65.

DR. NEWHOUSE: It's probably most of them because end-stage renal --

DR. ROWE: Well, probably most, but I just want to make the point, maybe 40 percent of the patients on dialysis are diabetics?

MS. RAY: Yes, that's true, it is about 40 percent.

DR. ROWE: And those people would be in their 30s and 40s?

MS. RAY: Right, but for this analysis right now, I explicitly excluded anybody less than 65.

DR. ROWE: So these are all people over 65?

MS. RAY: Right, this is a subset of all Medicare beneficiaries with diabetes. It's a subset of them.

DR. ROWE: Those over 65 years old? That's the definition of the subset?

MS. RAY: Over 65 years old plus they had to have Part A and Part B, plus a couple of other minor --

DR. ROWE: Clinical diabetes?

MS. RAY: Yes, yes. They had to have diabetes.

DR. ROWE: Sorry to interrupt. Thank you.

DR. LEWERS: Can I get one other clarification? You used the example of a diabetic-related chronic complication is hypertension.

MS. RAY: Yes.

DR. LEWERS: Which is not necessarily equal to diabetes. How did you define that when 90 percent of diabetics, these aren't all insulin-dependent diabetics?

MS. RAY: No, they're not.

DR. LEWERS: That they have a complication sounds terribly high to me.

MS. RAY: I'm not necessarily saying that diabetes caused the hypertension, but hypertension, at least in my previous work with the ADA, is considered to be one of the many chronic complications of diabetes. So I'm not saying it's a cause and effect at all. I'm just stating that approximately three-quarters of the patients self-reported hypertension and that hypertension has been reported as a chronic complication of diabetes.

DR. LEWERS: We could debate it, but that's all

right.

MS. RAY: I've done some initial comparisons of our study population to all Medicare beneficiaries. We will be doing additional comparisons and provide you that information during the April meeting. But my initial comparisons compared to all Medicare beneficiaries, beneficiaries with diabetes are more likely to be non-white, self-report fair or poor health, have lower incomes, but have the usual source of care.

DR. CURRERI: What does the term or more likely to -- I mean, is this a significant difference?

MS. RAY: No, this is just an initial result. It's not significant.

DR. CURRERI: It hasn't been statistically --

MS. RAY: No, I have not done that yet. I have not done any relative risk analysis, no. The same goes for this slide. This was not statistically tested yet, but compared to all Medicare beneficiaries, Medicare beneficiaries, those with diabetes seemed to be equally likely to at least a similar percentage of reporting having supplemental private insurance and delaying care due to

cost.

And again, similar to the overall population, beneficiaries with diabetes in general seemed to be pretty satisfied with their medical care. Most seek physician care when they have a problem, and most do have a positive perception of physician quality, as indicated in the table of numbers that I've provided.

What we found in terms of the use of preventive care services, however, despite wide release of medical guidelines, the majority of beneficiaries are not receiving many of the recommended services. Two-thirds of patients did not have a needed hemoglobin A1C, which measures how well their glucose is being controlled. One-half of beneficiaries did not have an annual eye exam or an annual lipid panel or an annual urinalysis, and approximately 20 percent did not have a follow-up physician visit within 28 days of a hospital admission.

These results are very similar to results published by other researchers like PPRC, like the GAO report of a couple of years ago, and some of the AHCPR report work.

DR. CURRERI: Did you say we were supposed to get a table with numbers on it?

MS. RAY: In the mailing materials.

DR. CURRERI: I didn't get any table in my mail. Did I just miss it?

DR. LAVE: It's in Tab D.

MS. RAY: Our next steps to be completed for the April meeting is to complete the analysis, conducting bivariate and multivariate analyses. At that point, we will have reviewed possible education and disease management interventions and will present recommendations for you to consider for the June report.

DR. WILENSKY: Nancy, let me just ask you and then open it up. In the title, you talk about the role of health care beliefs and perceptions, but all of the information that has been presented is outside of the belief and perception mode. What are the kinds of beliefs and perceptions that you're going to be including?

MS. RAY: The information available in the Medicare current beneficiary survey includes many of the variables presented on the table such as how do you perceive

your physician, do you think your physician is listening to you.

DR. WILENSKY: But not in terms of beliefs and perceptions with regard to the efficacy of medical treatment.

MS. RAY: No. We definitely have to work with what's available right now. I think one of the future, hopefully, things that will come out of this is additional work that we want to do in this area in gathering information.

DR. WILENSKY: You can see when you have this information, but this notion about to what extent beliefs and perceptions influence use of preventive care and you cite a number of very low statistics elsewhere, and I think that the notion of talking about beliefs and perceptions, I guess, to my mind, is as long as it's clear how you define it, it's okay what you're doing.

But these are more measures of perceived satisfaction and perceived quality, but not beliefs and perceptions about the health care system. I don't know what we know about that as to why people don't avail themselves

of covered preventive health care services for which they have a presumed medical need.

I guess the beliefs and perceptions -- when I'm thinking about that, if that's being the issue that you're trying to address, it would be, you know, what's the likelihood that this kind of health care is actually going to do something for the kind of health problems I have. There may be that there's just no way of commenting about that, but that was more what I was looking for.

I was surprised just by the title that my expectations had gone down a different direction. Judy.

DR. LAVE: Actually, I had two points and that was certainly my first point. I strongly recommend that you change the title of this because it has nothing to do with beliefs and there's nothing to do with perceptions.

I guess the other question that I had was that I thought it was interesting, but in many ways, it's kind of misleading because you have 1996 data, so that, in fact, you really can't answer anything about the BBA 1997, so you may want to talk about putting baseline information in place, but you can't make that leap.

MS. RAY: That's correct.

DR. LAVE: The other concern that I had is that I wish as a commission we would try to decide what we mean by access, because everybody means a lot of things by access and some people mean -- you use it here almost in terms of the use of services, and I think the use of services is different than the access to services.

We may want to have different words, but I do think that maybe not today, but some time we should decide what we want to mean by access and have a definition for it. But I think that what you're talking about here primarily is the use of services, if people use these preventive services less, whether they have more or less access we don't know because we don't know where they are, who they are, what kind of recommendations they're getting for them.

So we can't say anything about in front of that, it seems to me, so I would recommend that we use the use of services and call this the use of services rather than access to care.

DR. NEWHOUSE: We need something a little more direct than the use of services.

DR. LAVE: Maybe, but I think that it isn't access to care because I think there are a number of things that one would want to know.

DR. NEWHOUSE: I take your general point.

DR. LAVE: Right. But I think you have to be a little more careful about how we're going to title it. I thought it was a lot of very interesting information in here about the use of services.

I have one final point, and I was telling Joe about this. I have real problems with somebody who takes -- with the approach that says, I'm going to look at people who are sick. We'll call them the people with hypertension, people with diabetes, people with cancer, and we're going to say, they cost 1.5 times as much as the overall population or 1.10 times as much.

You would expect them to cost more because, in fact, the overall population contains a significant number of people who are very healthy. So almost by definition, if you pull out people by disease, they're going to be more costly than the relative definitions. So I don't think that's very useful and I think to some extent it's even

misleading.

MR. MacBAIN: A question on some of the specific use statistics. First of all, is this all self-reported data or when you get into things like lab tests, is that off claims data?

MS. RAY: The identification of the study population is based on either a self-report or a hospital admission or a drug use of insulin or oral sulfonylureas.

MR. MacBAIN: When you say, for instance, that two-thirds did not have at least one hemoglobin A1C --

MS. RAY: That's based off of claims data.

MR. MacBAIN: That's claims data, so they didn't have to know what that was.

MS. RAY: Right.

MR. MacBAIN: The figure that struck me most in all of this is, you say that approximately 10 percent did not have at least two physician visits during the year, meaning 90 percent saw their doctor twice or more, saw a doctor twice or more often, and yet, anywhere from two-thirds to one-half, depending on the test you look at, did not receive a test that you would have expected them to get.

It doesn't seem to have anything to do with the patients' attitudes or perceptions or access to care as we would normally measure it, but that given all of that, given the fact that they're seeing a physician still things that we would expect to see didn't happen, which is a different issue entirely from where this started out.

It's a very important one, but it just struck me that sort of buried in all of this was this real disparity between frequency of seeing physicians and frequency of getting necessary lab work.

MR. SHEA: Can I just follow up on that? Is there anything, Nancy, that was in the Balanced Budget Amendment that got to looking at the provider side of the diabetes situation or was the only item for special treatment this education provision? I was just looking at the beneficiary.

MS. RAY: I believe it's just the beneficiary education, but I will double-check on that.

DR. CURRERI: I may have missed it, but what was your sample size combining all these different things?

MS. RAY: It's on the top of each table. It's about 4 million in each year.

DR. LAVE: No, how many in the CBS?

MS. RAY: Oh, the MCBS? It's about -- I think about 1,300.

DR. CURRERI: I just think it's a little dangerous to say that this is more prominent in non-whites than whites. I mean, the difference in this annex is 7.6 versus 6 percent on a sample of 1,300 people. Maybe that's significant, but it seems to me a little dangerous to make that inference until you have a chance to analyze the numbers, because that's not a very large sample size, 1,300 people.

DR. KEMPER: I wondered if you could just say a little bit more about the motivation and what you would do with the findings. Let's say, for example, we found that the receipt of some of the various tests and so on was greater if people had greater confidence in their doctor, for example. Where would you go with that in terms of --

MS. RAY: Right. I think where I would go with that is perhaps there is a need for additional health patient education and disease management interventions to educate patients better, to make them more willing to go

across the street to the clinic to seek care, and that the BBA has, at least with the diabetes self-management training, has opened up the door a little bit to that and to the need to empower patients, that they can learn about their condition and they can understand their condition and that they can know what's needed and being able to take better care of themselves.

It's funny because this just happened to a family member of mine. They were told that they have high cholesterol, so watch your diet, and that was it. Having health education and understanding about the condition and learning about the condition, empowering the patients, I think, might improve.

DR. KEMPER: I guess I just have a little concern -- I guess it's a little unfair since we don't have the results yet, but that whether we'll actually be able to go from these relationships to some findings about what ought to be done, especially since the benefit has already been passed.

I guess the other --

DR. NEWHOUSE: Peter, I would have thought what we

are doing here is generally just monitoring time trends.

DR. KEMPER: That was my next thought, was there are two interesting pieces in here. One is the time trend, although on that, I had a really hard time, and I think it would be useful if we're going to talk about that, for you to interpret the results because they seemed quite different, even some of the measures from the same time period, it looked like there had been a decline over time comparing to the previous results.

So I wasn't sure whether it was getting worse or not. But again, that time trend ends before a major change in response to that. So I guess my final comment is that some of the flu shot and other things, if we were going to monitor trends, you might want to do that for the whole population rather than for this subset.

Just one final comment. The other question is whether these tests and so on compare to the guidelines of what you'd expect. That would be something else that might be interesting to show.

DR. ROWE: Nancy, a couple clinically oriented questions here. Could you tell us one more time how you

define patients with diabetes? They were on insulin, sulfonylurea?

MS. RAY: Or they self-reported diabetes or they were admitted to the hospital for diabetes.

DR. LAVE: Would they self-report being on insulin because this is not a covered Medicare benefit?

MS. RAY: No, they don't self-report being on insulin.

DR. NEWHOUSE: They self-reported diabetes.

DR. LAVE: So how do you pick up the outpatient drugs?

MS. RAY: Through the cost in use file, the prescribed medicine file.

DR. ROWE: Let me make a couple --

DR. NEWHOUSE: Can you say more?

DR. LAVE: Can you say more, because Medicare doesn't cover outpatient drugs.

MS. RAY: Yes, but part of the MCBS, they gather that information for the cost in use component. Actually, the cost in use part of the MCBS, the 1996 is not available yet because they have to gather the information like

prescribed medicine. That's not a covered expense.

DR. ROWE: Let me make a couple suggestions. One is that in your analysis, even though it may be a small number of patients, I think you should take out the patients with end-stage renal disease or analyze them separately.

With respect to access, if they see health care providers three times a week, their costs are going to be enormous. They are a different species of patients, by definition, and they may be a small number, but they may have a very significant impact on your data and prevent you from really being able to see some relationships that are there otherwise.

So I think if you want to do the analysis with them in it, you should also do it with them out of it just to see. Ted, does that make sense to you?

DR. LEWERS: I agree.

DR. ROWE: Secondly, I think one of the interesting things that happens as you get older, and particularly as you get older and you get sick, is you develop a syndrome which is very, very common which is known as the pseudodiabetes of aging and that is, your blood sugar

goes up, it particularly goes up in response to medications like prednisone and other things. It goes up when you're acutely ill and under stress. It goes up when you lose weight, it goes up when you gain weight, it goes up postoperatively, et cetera.

And so, you're in the hospital and your blood sugar is a little high, and either you're diabetic and the doctor ignores it and says your blood sugar is a little high, but it's okay for your age, my dear, which is not so good, or you're not diabetic, but you get labelled as being diabetic because you had a high blood sugar on two or three occasions in the hospital.

Just like you could get labelled as being hypertensive because you had a high blood pressure on one or two occasions. But once you've recovered from your operation or gained your weight back or lost your weight back or whatever, this goes away, or you're off your medicine that caused it.

So the point of this is that there's a significant proportion of old people walking around who tell you they're diabetic who are not, because somebody told them they were

diabetic at some point. And so, I think it would be interesting for you to at least do a little bit of a longitudinal validation.

Remember a couple months ago we heard about the patients with paraplegia who'd had it one year but not the next or quadriplegia? So how about diabetes? I would like you to use your criteria and include only people who met your criteria three years in a row or something. I mean, diabetes doesn't go away once you have it.

That way you would have a homogeneous population of people who are more likely to actually have been diabetic. See if it makes a difference.

MS. ROSENBLATT: I have sort of a half-formed question that gets at insulin. I don't know enough about diabetes, so maybe one of the clinicians here could help me out. It's my understanding that there's also daily testing that's very beneficial in the treatment of the disease, and my guess is that the tools needed for the daily testing are also not covered if insulin is not covered. Is that true?

DR. ROWE: They would be covered in some of the Medigap policies.

MS. ROSENBLATT: But not under Medicare?

MS. JENSEN: I think the supplies used for blood glucose testing are now covered.

MS. ROSENBLATT: Okay. That's my question.

MS. RAY: For this data, because it's older data, it would only be for insulin users, I believe.

DR. CURRERI: I just wanted some clarification on Table 3. You present this data as percent of the population that has had these preventive care measures. Now, a pap smear in the last three years, is this a percentage of all the population or a percentage of females?

MS. RAY: That's the percentage of females and that's based on a self-report.

DR. CURRERI: You need to say that because I assumed that was really 50 percent and 80 percent for mammography because it says percentage of the population. The other thing you have to be a little bit careful about is, I don't know what the proportion is, but a lot of these ladies have had hysterectomies, so you wouldn't expect them to get a pap smear in the last three years, and I think you need to eliminate those people, and it's probably a

significant proportion. It may be 20 percent, I would say.

DR. ROWE: You won't know, though, because it didn't occur while they were Medicare beneficiaries.

DR. ROWE: It happened in their 30s or 40s.

DR. CURRERI: That's right. But I would think that the rate is probably much higher than the 24 percent.

DR. ROWE: Of the susceptibles.

DR. CURRERI: Of the susceptible people and you can't do a pap smear if you don't have a cervix.

MR. MacBAIN: A couple of comments on the question of patients with pseudodiabetes. If we're concerned about attitudes and cultural perceptions related to access, if people think they have diabetes, that would qualify them for the study because we ought to see what happens based on their attitude, so I'm not sure we gain anything by --

DR. ROWE: You could call it attitudes and perceptions of people who may or may not have diabetes.

MR. MacBAIN: Who think they're sick, yeah. I mean, they're going to behave the same. They're going to behave as if it's true if they believe it's true and that's probably of more interest to us. The other thing is that

those are the ones who are going to show up as self-reported. They won't show up in the other statistics, and I think we'll find that that is a very persistent statistic, that once they've been told that their diabetics, they're going to report themselves as diabetics year after year, so I'm not sure that we can filter them out anyway.

DR. ROWE: With all due respect, I would say I think you're probably right, but there are a fair number of patients out there who get labelled as diabetic, get put on the sulfonylurea and then when they recover from whatever or they get off the steroids or whatever, the doctor says, you know, maybe you weren't diabetic after all. I think the attitudes and perceptions, if somebody thinks they're diabetic, then that is interesting. It would be -- but if they think they're diabetic two or three years running, we're more interested in them than just one year. Do you accept that?

MR. SHEA: Nancy, you've gotten a lot of helpful suggestions here for your analysis. I had a question. I think this is actually difficult as it may be to structure it. I think this is an important and potentially very

useful issue to look at over time.

Is there any experience in the active population along these lines? Has anybody studied this among active workers or looked at disease preventive strategies that are being done in a working group population?

MS. RAY: You mean specific interventions that are being used to -- I'm sorry.

MR. SHEA: Are any studies parallel like parallel to this in the active worker population, not Medicare?

MS. RAY: Not Medicare. There have been studies that have looked at use of preventive care services among active workers -- among people under 65. Using those same series of satisfaction variables and physician perception variables, not that many, no.

DR. NEWHOUSE: Does MEPS have any of these questions?

MS. RAY: Yes, MEPS has some of these questions.

MR. SHEA: It might be useful just to have some. If you think there's anything valuable in that, it might be useful to include it in the next discussion for comparison.

DR. WILENSKY: Any additional?

DR. LAVE: I do have a question, and this is a clinical question, Jack, Ted, Bill. Is there a difference on average in the nature of the diabetes that is held by the employed population versus the over-65 that you would expect should or would influence some of these variables? I would imagine you have more Type I and Type II. Do Type I and Type II diabetes vary with age?

DR. ROWE: Yes.

DR. CURRERI: There are many more Type II diabetes in the older age groups.

DR. ROWE: Yes, what we now call non-insulin-dependent diabetes. I think the important thing, from my point of view, would be that the complications of diabetes, which occur in the eye, nerves, in the kidney, vessels as you mentioned, Nancy, are chronic complications. The important thing is how long have you been diabetic. That's more important than whether you are or are not on insulin or you have a Type I or a Type II or so on.

So the patients who enter our program as beneficiaries with the preexisting diagnosis of diabetes for some period of time are really an entirely different

category of people than the people who develop diabetes late in life, at age 70 or 75 or 80, and thus have that much less duration of the disorder. I think that would be the clinically important criterion, if we were looking at a lot of data. This is interesting, but this isn't really what we need to do, but that would be the way I would approach it. Does that make sense, Bill?

DR. CURRERI: I agree with that.

DR. WILENSKY: Nancy, thank you. The next session is on the preliminary results from the survey of physicians about the Medicare program. Kevin and Julie.

MR. HAYES: As you know, the Commission has sponsored a survey of physicians. It's meant to collect data on physician's perceptions about the traditional fee-for-service Medicare program. We're asking questions about how they feel about payment rates, whether or not they're accepting new Medicare patients, and related issues.

The Commission has contracted with Project HOPE and the Gallup organization for questionnaire development, data collection, and analysis of the data, and we're happy to have with us today Julie Schoenman from Project HOPE who

is directing work on the survey and she will be presenting preliminary results.

We thought it would be a good idea for her to do so because we hope to summarize the results of the survey in the June report, and we're hoping for some feedback from the commissioners about key points that are in the survey, key findings that are of interest.

We're also interested in feedback on how to proceed with this kind of activity in the future, how often we should conduct these kind of surveys, are they useful, other things that you think we should be asking in these surveys and so on. So I'll be turning the slides for Julie and turn things over to her.

MS. SCHOENMAN: Thank you.

DR. WILENSKY: Welcome.

MS. SCHOENMAN: Thank you for having me. This survey of physicians had three main purposes. Primarily we were interested in collecting data with which to assess the impact of the 1998 Medicare fee-for-service payment changes. We also wanted to collect data that you could use in the future to assess any payment changes that you make in the

future.

And finally, we wanted to compare data that could be -- collect data that could be compared with data that had been collected by PPRC in late 1993/1994 so that we could analyze certain trends in variables such as physician satisfaction, acceptance of new patients, and problems with medical practice today.

We asked a variety of questions in this survey. We have several questions on there, attitudes and concerns about medical practice today, changes that they had made in the past year, acceptance of new patients was given a great deal of weight.

We asked about priority that they give to Medicare fee-for-service patients when they seek appointments, impact of Medicare fee-for-service payment changes, and finally, a few questions just to provide some exploratory information on the Medicare private contracting option that was passed as part of the BBA.

I should just note very quickly, Medpac was not identified as a sponsor of this survey unless the respondent asked specifically what the focus was and who was behind

this, and most of the questions in the early part of the survey, as you can see from the questionnaires that you got, in those questions, Medicare fee-for-service is one of several other payers, so we tried very hard to not single out our focus on Medicare.

Some of the questions at the very end obviously dealt specifically with Medicare and there we kind of tipped our hand.

DR. LAVE: Can you tell us the difference between the A and the B?

MS. SCHOENMAN: Sure, I'd be happy to. When we developed this survey, we started with the 1993-'94 NORIC survey and we kept questions that we thought were relevant, we got rid of topics that weren't, and we added our own questions. There were several questions specifically that asked about "problems with medical practice," and we felt that they were a little bit loaded in the terminology that they used, and so we decided to employ a split sample approach.

So half of our sample was given the old questions and half of the sample got a new set of questions that asked

a little less leadingly, I think. It was, are you concerned about these issues. Today I'll just talk about the problem posing of the questions because it's the ones that we can use for trend analyses.

But I could just basically say that the concerned questions gave us more or less the same patterns. More physicians were willing to say they were very concerned about something than to say it was a very serious problem. So the threshold was a little lower, but the patterns were very consistent.

The sample for our survey was drawn from the AMA master file and physicians were eligible if they provided at least 20 hours a week of patient care, spent at least 10 percent of their patient care time with Medicare fee-for-service patients, were not in training, were not a federal physician, and were not one of our excluded specialties, which would be pediatrics, be hospital-based radiologists, anesthesiologists, pathologists, and nephrologists as well because of the special treatment of ESRD.

That's basically the same criteria that were used for the NORIC survey, so the samples should be comparable.

We had a core sample of 1,000 target completes and then we had three oversampled specialties of 200 each, and those were in cardiothoracic surgery, ophthalmology, and orthopedic surgery, and those were selected because we had some concern that those specialties may have been very hard hit by the recent payment changes.

As Kevin said, Gallup was responsible for our data collection. We used a mixture of mail and telephone surveys, and at the very end of 1998, we sent out the mailing to all eligible physicians. They got the mailed surveys that you saw, and they received an incentive payment with that mailing.

Response in the early part of January was really quite tremendous. We got a lot of mail surveys back, and then at maybe mid to late January, Gallup started CATI interviewing to try to pick up the remaining cases.

They pulled an interim file for us in early February so that we could present data to you today. Ninety-six percent of the data that we'll be presenting today came from the mail surveys because it's that initial wave of response.

An important point to keep in mind is that the data have not yet been weighted for the higher probability of selection of the oversampled specialties, so it's a little bit more over-representative of surgeons and to the extent that they are driving, that they're more likely than other types of physicians to do something, it exacerbates the findings somewhat today.

DR. LONG: How large was the incentive?

MS. SCHOENMAN: Twenty dollars and it seemed to work. A lot of them sent -- either the timing was perfect, it was just right after the holidays, but we got a tremendous response back from the mailing.

DR. ROWE: That's the answer to what's the impact of the BBA.

MS. SCHOENMAN: You may be right. The very first question after we established that the physician was actually eligible was a general question, how satisfaction are you with the practice of medicine today. It's exactly the same question that NORIC used five years ago. It's in exactly the same place on the survey, so the data should be very comparable.

I think the important finding here is that fewer physicians today report being very satisfied. So satisfaction has declined in the last five years. This decline was pretty much across the board regardless of specialty grouping, and there was very weak evidence that, not surprisingly, physicians with higher incomes tended to be more satisfied with the medical practice.

DR. CURRERI: How much of that effect do you think is due to the oversampling? Because these are not big changes or are they big changes?

MS. SCHOENMAN: Well, I can't test for significance because I don't have the '94 standard errors or anything like that.

DR. CURRERI: Could you give us an educated guess? I would guess that the surgeons would likely say they're less satisfied because they took the biggest hit.

MS. SCHOENMAN: In 1999, the ratings did not vary by specialty grouping, by urban-rural location or by the percent of time they spent with Medicare patients. It was very consistent across the board.

DR. ROWE: If the usual customer measures of

variance that you have available in your data set are similar to what we might assume would be the measures of variance in the same population measured five years ago, would these changes be statistically significant?

MS. SCHOENMAN: That's a good question. I did not test for that so I don't know.

The next series of questions on the survey asked physicians to rate the seriousness of five different problems with medical practice, and these problems were paperwork and administrative hassles related to billing, external review and limitations on clinical decisions, reimbursement, malpractice, and the high cost of practice.

These again are the same questions that NORIC used five years ago, so we can compare the '94 and the '99 numbers. We do see that for four of the five problem areas, the percent of physicians saying it was a very serious problem has increased. Again, that could be somewhat driven by the surgeons particularly for the reimbursement, which is quite a large increase.

They were much more likely than the average physician to say that reimbursement was a very serious

problem.

MR. MacBAIN: Again, with the probable exception of reimbursement, we can't say if any of these differences are really significant.

MS. SCHOENMAN: Correct. The other thing to take away from this slide is that the three problems that were big in '94 remain big in 1999 and that is billing, paperwork, and reimbursement and high cost of practice.

We also asked physicians to rate three of those factors for various types of payers, and here the blue bar is Medicare fee-for-service and this was tested. This is just 1999 and we were able to test the percent of physicians who said that the given issue was a very serious problem for Medicare fee-for-service and see if it was statistically different from the other three different types of payers.

The little asterisks above the bar indicates that yes, it was. So for reimbursement, physicians are more worried about Medicare fee-for-service reimbursement than they are for private payers, but they're not as worried as they are for Medicaid fee-for-service or for capitated HMO patients.

DR. CURRERI: Now what are we comparing this to? In other words, you have an asterisk above the red on the left under reimbursement.

MS. SCHOENMAN: It means that it's compared to the blue bar in that same series.

DR. CURRERI: So everything has been compared to the blue bar?

MS. SCHOENMAN: Yes.

DR. CURRERI: And that's with a confidence level of 5 percent?

MS. SCHOENMAN: It's 5 percent.

DR. ROWE: This HMO is only capitated?

MS. SCHOENMAN: Right. The payers are defined as private is PPO and other fee-for-service patients. Medicare fee-for-service is exactly that. Medicaid is strictly fee-for-service, and then everyone else who's capitated, be they Medicare, Medicaid, or private are lumped into the HMO category.

DR. ROWE: But not all HMOs are capitated.

MS. SCHOENMAN: That's correct. So if it's an IPA, it's --

DR. ROWE: So it's a subset of the HMO.

MS. SCHOENMAN: Yes. HMO means capitated in this.

DR. LAVE: How was it defined for them? Was it defined as capitated or was it defined as an HMO?

MS. SCHOENMAN: It was defined as HMO and other capitated.

DR. LAVE: We know that HMOs are capitated, but they may think capitated --

DR. LONG: HMO and other capitated claims.

MS. SCHOENMAN: We always kept the same ordering of payers. Let me just say, we were to some extent constrained because we wanted to keep comparable categories as much as possible to prior data collection, the NORIC survey, and we also were very careful to always ask these payment categories in the same order so it was, in a way, conditioned.

The first one was PPO and other privately-insured fee-for-service patients, Medicare fee-for-service, Medicaid fee-for-service, and they explicitly said excluding HMOs, and then the last one was HMO and other capitated.

MR. MacBAIN: So there's no way to answer for a

fee-for-service HMO?

DR. NEWHOUSE: That's right.

MR. SHEA: And these are both Medicare HMO and other HMOs, right?

MS. SCHOENMAN: Yes.

DR. LAVE: Let me try to explain it. I come from Pittsburgh and just to sort of give an explicit example, a number of the patients in the Pittsburgh area are under traditional fee-for-service medicine and they have a standard Medigap policy.

A number of them are under Medicare risk plans for which the Medicare risk plan gets a per-member per-month fee which I would think would be a capitated payment. The HMOs, particularly with the surgeons, I don't think that any of the Medicare risk plans have capitated their surgeons.

So if I was a physician, would I think -- how would I take a patient who was under a Medicare risk plan compared to a traditional fee-for-service because they have different rules, they have different reimbursements, they have different paper requirements, and all of the rest of it.

DR. WILENSKY: On the survey you'd have to define yourself HMO and other capitated.

DR. LAVE: Why?

DR. CURRERI: Because you're getting a fee-for-service from the HMO plans.

DR. NEWHOUSE: You wouldn't even necessarily know how the HMO was --

DR. ROWE: Who's at risk here? If the doctor is at risk, this is a survey of doctors, not of patients. If the doctor views himself as at risk, he's taking the risk, and he considers that patient to be capitated --

MR. MacBAIN: Not necessarily. It could be a fee-for-service requirement.

MS. SCHOENMAN: They still know. I would think that the patients coming from the Aetna HMO --

MS. NEWPORT: No, not necessarily.

DR. LAVE: This is actually an extraordinarily important issue because the Medicare HMOs, which pay fee-for-service to surgeons, which is the way they all do in Pittsburgh, none of them have capitated their surgeons, they have different paper requirements, they have different

reimbursement payment rates, so they vary from what it is.

They have different clinical review procedures. So it would be very important --

DR. ROWE: It's not an important issue for two reasons. One is that it's a quarter after 3:00. The other is that the doctors don't like HMOs, which is what your data show, which we knew anyway. So what's the difference what kind of HMO it is? All it's telling us is --

DR. LAVE: We want to make sure --

DR. ROWE: Is this going to be a headline tomorrow in Pittsburgh that doctors don't like HMOs?

DR. LAVE: I just want to make sure that they are -- Connie knows people as HMO patients and not as fee-for-service patients. The issue is sort of where they are putting them on the thing and if they define capitated the way you capitate it, they would not have them referred to under that column.

DR. ROWE: But they still wouldn't like the HMOs.

DR. NEWHOUSE: So these are understated.

MS. NEWPORT: Except in Denver.

DR. LAVE: Sorry, but I think it's an important

problem.

MS. SCHOENMAN: You're right, it's always a problem in designing these surveys, and to some extent, we were constrained by being able to make comparisons.

DR. NEWHOUSE: But this raises a general question, Julie, how long -- if this is breaking down how long you -- whether at some point you have to --

MS. SCHOENMAN: We did change it. We tried to clarify it. I don't even remember -- I think NORIC just said Medicare and we tried to split out and say fee-for-service because that's really what we are interested in and we had to put the Medicare HMOs somewhere else, and where they fell was the last category down.

MS. NEWPORT: What was the geographic distribution of the survey respondents?

MS. SCHOENMAN: I haven't looked at that specifically yet.

MS. NEWPORT: I would just suggest that there's variability from East Coast to West Coast and the types of understanding and contracting that providers have. There may be --

DR. WILENSKY: This is a national project.

MS. SCHOENMAN: And also, the core sample was stratified by urban/rural location and then drawn in just proportion to that distribution.

MS. NEWPORT: Well, it just speaks to this prior discussion in terms of understanding. Some specialists will have no clue if that was a capitated patient or not.

DR. CURRERI: What did you do with the -- if they checked that box that said less than 10 percent, did you eliminate those?

MS. SCHOENMAN: They are eliminated from the analysis. In the phone survey it was very easy to build that skip pattern into the interview protocol. The analysis is limited to people who provided at least 10 percent -- spent at least 10 percent of their patient time with the given type of patient.

DR. CURRERI: So your total number of responses then is how satisfied or concerned they were varied in the end number because I assume that the number taking care of Medicaid would be much lower.

MS. SCHOENMAN: Yes, it is. In fact it is. Those

are in the tables that you received. There were some ends on those tables.

Very quickly, this is just a comparison of the numbers that we got with the 1994 numbers, and however you want to construe HMO as defined, HMO is where the action is in terms of growth and these issues being viewed as a serious problem.

Medicare fee-for-service was generally a pretty modest increase, if at all, and it was always less than the HMO sector and in the private fee-for-service sector.

Physicians were asked a series of four questions as to whether they were taking any actions or had taken any in the last year to change their practice in response to some of these pressures. There were two questions about whether they had tried to reduce practice costs and there were two as to whether they had tried to increase revenue.

In fact, most physicians, the majority seemed to be indicating that they were trying to take some action in response to these problems.

DR. LEWERS: In looking at the survey and the material, reduced staff costs included layoffs and other

factors. There's no way we're going to pick out whether they have reduced their staff, because that was the point which we made when we first went over preparing this survey, that one of the very key elements in access to patients is, are the physicians reducing their staffs.

The impression that I have in particular is yes, they are. But we're lumping, have you reduced staff costs. That means that you've cut your health insurance benefit, which a lot of people are doing. So reduce staff costs, I think, is significant, but it's not giving me the information I need to define the impact that's going to be on the beneficiary.

MS. SCHOENMAN: There were several questions on the survey about acceptance of new patients. We asked, are you currently accepting new patients of any type. If they said yes, then we followed up with, are you currently accepting all, some, or no new patients of a given type, and again, the types are the ones we've discussed above, plus an uninsured patients.

Then we asked the same questions as of 1997, were you accepting new patients and of given types. Then NORIC

had asked this similar set of questions for 1994. So we can compare three points in time. I think the two bars that are most directly comparable are the yellow bar for 1994 and the red for 1999, and it certainly looks like acceptance of patients has gone up in most cases.

The one caveat here is that surgeons are more willing to accept patients than others, I think, because of the referral nature of their business. They're over-represented in this database, so the increase may not hold up when we do the final weighting.

But the big point here, though, is that the Medicare fee-for-service acceptance is right on a par with the private. It's certainly no worse and, in fact, better in some years and it's certainly better than for the fee-for-service Medicaid and for HMO and for uninsured patients.

DR. LEWERS: When you talk about accepting a new patient, the question in the questionnaire says all or some and you're lumping all or some.

MS. SCHOENMAN: Correct.

DR. LEWERS: And the data from two other surveys recently don't correspond with this. The AAFP is beginning

to see that physicians are not accepting patients. The Lewers private survey tells me that we're running into more people as I travel who are not taking new patients.

DR. NEWHOUSE: And that's statistically significant.

DR. LEWERS: That is very statistically significant.

DR. ROWE: That's the Maryland Eastern Shore survey.

DR. LEWERS: No, that's countrywide. But the '98 SMS/AMA survey, this is very preliminary, but 78 percent of MDs accept all new Medicare patients, 7 percent are not accepting any Medicare patients. So it doesn't correspond with this, and we've got two other surveys which are not corresponding and I think we have to take a look at why isn't that the case and maybe by the time you get around to doing a final on this, you can get some of those figures by that time.

So putting all and some is a difficult mechanism, but it's just not jiving with other surveys.

MR. SHEA: Is that the way the questions were

worded previously?

MS. SCHOENMAN: In the NORIC survey, it's exactly the same. The '97 is not because that was a new set and it's asking them at this point in time to think back a year ago, and that wasn't done in '94. But in '94, they asked, are you currently accepting and in '99 they ask are you currently accepting. I think that you're quite right and we'll look at the other data, and again, it's cautionary because of the surgeons in this with the overweighting.

DR. LEWERS: I'm just talking all number now, not breaking down by category.

MS. SCHOENMAN: You're saying 7 percent don't?

DR. LEWERS: Of all physicians, not breaking it by specialty.

DR. LAVE: Maybe they can break down all or some from the data they have, Ted. If you look at the question, they --

DR. LEWERS: I think we should. I don't think the combination there is important.

MS. SCHOENMAN: We also were concerned, obviously for the three oversampled specialties who had been

particularly hard hit by the fee changes as to whether they had decreased their acceptance of Medicare fee-for-service patients, and right now, the data are showing that they don't.

The only place that it declined at all was for orthopedic surgeons. It was a very small decrease. It's not statistically significant and even there, it's consistent with the '97 numbers being higher than the '99 numbers that we saw in general on the earlier graph. So we're not currently seeing evidence that access as measured by acceptance of new patients has declined.

DR. ROWE: Julie, I had heard this week that there was a Medicare survey that showed that the utilization of certain tertiary care services by Medicare beneficiaries was declining, that cardiac surgery rates and orthopedic surgery rates in Medicare beneficiaries had declined over the last couple of years.

This presumably came out of HCFA. I don't know that, and there was a lot of concern about what that may mean and whether that was a response to these reductions in reimbursement or an access problem related to other changes

in the health system. Has anyone else seen this or heard of this? Bruce mentioned this yesterday, that there had been these data.

MS. SCHOENMAN: I'll try to look into it.

DR. ROWE: This came up in a meeting when we were talking about our cardiac surgical volume or something and he said, well, there's some new data. Is there someone from HCFA here who knows the answer to this?

I think we might just ask, okay?

MS. SCHOENMAN: Yes, definitely.

DR. LEWERS: Julie, can I just ask, why did you pick these three specialties?

MR. HAYES: I can answer that. When we looked at changes in payment rates from 1997 to 1998, there were three types of services that were affected most by the payment policy changes that were implemented in '98, coronary artery bypass graft, cataract lens replacements, and two types of orthopedic surgery procedures, knee replacements and hip replacements.

So that told us that given that these three specialties provide those four categories of services, that

told us that these three specialties might be good to focus on as we look at changes in acceptance of new patients just to see if their perceptions and their practice of medicine changed.

DR. LEWERS: I think we would have predicted what you're seeing. Ophthalmologists are not going to give up cataract surgery. A cardiac surgeon who has a bypass to do has a bypass to do and is not going to make a decision on the basis of that. They're not going to be happy with it, but they still have to do the procedure. I knew that was going to be your answer. I was hoping maybe there was another reason.

DR. ROWE: Don't you think there are two hypotheses? I mean, just to be fair, one hypothesis is that the doctors want to provide these services, they're trained to do it, and they serve the patients and within any reasonable payment they'll do it.

The other hypothesis the economists might offer is they were getting overpaid before and reducing the payment by access has no impact on the --

DR. NEWHOUSE: I've heard some of my colleagues

say that, yes.

DR. ROWE: What do you think of that, Joe?

DR. NEWHOUSE: There are two alternative hypotheses.

DR. WILENSKY: And it's not clear if you see a decline in rates that you're not seeing a movement toward a more appropriate rate. In this country, we do many, many more bypasses. It's hard to have unless you know more about where it's going on and why it's going on and the health status.

DR. NEWHOUSE: But that's also true of -- you do more, I mean, people are doing more to make up revenue. Well, is that good or bad? I don't know.

DR. CURRERI: Could I ask a question about Table 16 which pertains to this slide? You have in there, if we look at Medicare and accepting new patients, that in 1999, proceduralists accepted 100 percent, surgeons 98.5 percent, and non-proceduralists 94 percent. The 98.5 percent and the 94 percent are attributed to surgeons and non-procedures. Is it significantly different from the population as a whole? That doesn't make any sense to me.

I'm on Table 16 under FFS Medicare, the top three numbers there. I just don't understand the statistics here.

MS. SCHOENMAN: Surgeons, the 98.5 is statistically different from the number for proceduralists and non-proceduralists combined.

DR. CURRERI: You're telling me that 98, 96 between proceduralists and surgeons in '94 is not significant, but 198.5 is significant?

MS. SCHOENMAN: No. The stars are within a column.

DR. CURRERI: No, I understand that, but let's go under 1994. Explain to me why --

MS. SCHOENMAN: I can't test anything for '94 because I don't have the standard errors.

DR. CURRERI: Why did we pick proceduralists to compare against? I mean, that's a very small population compared to the other populations.

MS. SCHOENMAN: It's surgeons versus everyone else, proceduralists and non-proceduralists combined.

DR. CURRERI: So where would everybody else be? If you had everybody else, it would have to be somewhere

between 98.5 and 94, I guess.

MS. SCHOENMAN: Probably.

DR. CURRERI: So 100 percent should have a star beside it. I mean, 100 percent is much --

MS. SCHOENMAN: But then it's too small, I think, for that.

DR. CURRERI: It's very confusing to me. There must be a better way we can look at this.

MR. MacBAIN: As I recall, didn't we get into this swamp because we were trying to test the hypothesis that the changes in the payment rates would cause access problems, that physicians would stop seeing Medicare patients because they weren't getting paid enough? So that's the hypothesis we're trying to test with this.

So while we may have predicted that we'd get the result that's up on the screen, it still makes sense to test that and I think we need to look at it in that context, is this is an attempt to test whether our prediction is accurate or not.

MS. SCHOENMAN: If you look at Table 16(b), the '97 and the '99 numbers are presented, and those are tested.

Those are still tested within a column, but I did test separately whether the difference for orthopedic surgeons was different and it's not.

DR. CURRERI: Then let me go to the 1999 Medicare, and you have for all physicians it's 97.2 percent are accepting new patients and you're telling me that 98.5 percent is significantly different but 100 percent isn't?

MS. SCHOENMAN: 98.5 is statistically different --

DR. CURRERI: Than 97.2.

MS. SCHOENMAN: No, from the weighted average of 194 percent, for the percents of the other two non-surgical groups. It's not compared to the bottom line.

DR. CURRERI: It's not compared to all physicians?

MS. SCHOENMAN: No, because they have to be independent samples, so you have to take the surgeons out of that 97.2.

DR. KEMPER: It's all other.

MS. SCHOENMAN: It's everyone but surgeons. We can try to clarify that.

DR. NEWHOUSE: Isn't the real issue whether we're worried about one percentage point difference?

DR. CURRERI: I don't know. It may be statistically significant, but probably not.

DR. WILENSKY: But trivial.

DR. CURRERI: Trivial, right.

MS. SCHOENMAN: I think what you're getting at is -- what we're measuring in terms of access measured by acceptance of new patients, there doesn't seem to be that much --

DR. WILENSKY: That is what it says. The fact is, to the extent that we're worried that physicians --

DR. CURRERI: That there would be a response.

DR. WILENSKY: It does not appear in these data as of yet, that there is a true --

DR. CURRERI: Now the next thing to do is to give this back to the actuaries so that they take away that 30 percent response reduction.

MS. SCHOENMAN: We thought we'd like to ask a little bit more about access and the possibility that access had declined in a more subtle way than just acceptance of patients. So the next set of questions ask whether they had made any change at all in the priority that they give to

their Medicare fee-for-service patients when seeking appointments.

Then of those who said they'd made any change whatsoever, we asked them if it had gotten much higher or much lower.

MR. MacBAIN: What does the end of '98 mean?

MS. SCHOENMAN: Only 10 percent of our entire sample said they'd made any change at all since 1997 in the priority.

MR. MacBAIN: So this excludes the no change at all?

MS. SCHOENMAN: Right. It's a very small number who even responded that they had changed in any way, and of that small number, a little more than half said that the priority had declined. So you can take it with a grain of salt. There may be some degradation of access as measured.

DR. NEWHOUSE: But it would be better to present this with the no change in.

MS. SCHOENMAN: Right. We were also interested in knowing whether physicians are even aware of the fee-for-service Medicare changes, and 74 percent, almost three-

quarters, said that yes, they were aware of the changes that had been made since 1997 and, not surprisingly, surgeons and proceduralists and all of our oversampled specialties were more likely than average to be aware of these changes, as were physicians who spent a greater proportion of their time with Medicare fee-for-service patients.

DR. WILENSKY: Did you make any attempt to see whether they had a correct perception of what the changes were?

MS. SCHOENMAN: It's coming. Of the people who said they were aware, we asked them to estimate the impact of the change on their Medicare revenue. The vast majority said that the change had decreased their Medicare revenue by at least 6 percent, 6 to 10 percent or more.

Not shown here, these surgeons and proceduralists were more likely to be in the real negative impact than the other types of physicians.

DR. CURRERI: So on the bottom line, that first little arrow should be pointing the other way, is that right?

MS. SCHOENMAN: Decrease by more than 10 percent.

DR. ROWE: Greater than 10 percent reduction.

DR. CURRERI: Okay, got you.

DR. LEWERS: Before you leave, can we go back to the slide before that? The 21 to 30 percent is different. Why?

MS. SCHOENMAN: It's not statistically significantly different, but everything else was.

The very final series of questions dealt with the private contracting issue, and these again were just designed to be exploratory questions to give you some feedback on what physicians know and feel about this issue.

The first question defined private contracting as it currently exists under the BBA regulations and asks them whether they were familiar with it or not, and I think it's pretty telling that 33 percent said they were not at all familiar and another one-quarter said they were not very familiar. So the level of awareness and knowledge about private contracting seems pretty low at the moment.

We then followed up with another question that explained basically the Kyl and the Archer amendments to expand private contracting on a case-by-case basis so that

the physician would not have to opt out of Medicare for two years for all patients and asked if they would be likely to try these contracts under that scenario, and more than half, 57 percent, said that they would be at least somewhat likely to do so.

So there seems to be some potential market increase in the number of physicians who are at least interested in this expanded option.

DR. CURRERI: Did you look at that or break that down by specialty?

MS. SCHOENMAN: We did.

DR. CURRERI: Because I think there's a big difference when you look at small specialties like neurosurgeons where there tend to be only one or two in an area that are more likely to go into private contracting than where there's a plentiful supply of them.

MS. SCHOENMAN: We didn't go that far just because the data aren't -- we don't have enough people in neurosurgery alone to do that. We did look by the three groups, surgical specialties, proceduralists who are medical specialists who happen to be procedurally oriented like

cardiologists, gastroenterologists, and then the non-proceduralists in the other medical specialties.

Surgeons and proceduralists were more likely to say that they would take expanded private contracting.

DR. WILENSKY: But that just really says, if somebody was willing to pay me more, I'd be willing to accept more money if it doesn't cost me anything?

DR. LEWERS: Which means they didn't understand the question.

DR. ROWE: I think a lot of these data are in that category, with all due respect to the value of the survey in terms of your own work and what have you. How is this likely to inform or --

DR. WILENSKY: I think the bottom line questions for us is whether there has been some response by physicians to the change in payment rate, and the answer is there appears to be some response, but not in terms of their willingness to see new patients. Something about their hiring practices or their ability to --

DR. ROWE: They're reducing their overhead or whatever.

DR. WILENSKY: Right, exactly. They're doing things, but they're not stopping -- they're not changing their Medicare patient response, at least according to this survey. Everything is just what else they're saying while you're talking to them, but the real interest is whether they report a willingness or a change in their willingness to see Medicare patients and if they're responding in some other way.

DR. KEMPER: Just one comment, that these are asked of the physicians that remain in practice and we don't really know what's happening to a number of physicians going into these specialties than dropping out.

DR. WILENSKY: That's a different study.

DR. KEMPER: But it seems like -- and obviously, in one year, you're not going to have a big affect on that, but that's another dimension of this that at least might be worth noting.

DR. CURRERI: One thing that concerned me though is that it did show that they were cutting staff costs and they were trying to reduce overhead and so forth, but there also was even a bigger increase in trying to increase

revenue, which to me means they're increasing volume, and the question is whether that's an appropriate volume increase or not. That's something we really need to look at because that could be inappropriate.

DR. WILENSKY: Right. We have to wait in terms of what we tell that actuary.

DR. NEWHOUSE: You could potentially make the same argument about what I'm about to say, but one of the things we know from studying variation in Medicaid fees across states is that in states where the fees are higher, the primary care physicians spend more time per visit. We don't have anything about that here and I don't know what the analog is, if there is any at all, for surgeons.

What there is an issue about is there are different -- basically a different product if the fees change.

DR. ROWE: We could break it. We could take the surgeons, we could break them into categories like ever spoke to this patient, you know, things like that. So there would be some analog.

DR. WILENSKY: Julie, do you want to finish your

presentation?

MS. SCHOENMAN: Just real quickly. We asked two follow-up questions of the physicians who indicated that they had some interest in expanded private contract and we asked them, would this option increase their willingness to serve Medicare patients, and four-fifths of them said yes, not surprisingly, and this was surgeons and orthopedic surgeons were more likely than average to say that it would.

That is, I think, interesting because those surgeons were already accepting most patients who came to them, but they had indicated a little bit of an unwillingness or a decline in priority given to these patients.

The final follow-up question that we asked was, who would their market be? With whom would they try to establish these contracts? Would it be just their new patients or would it include their existing patients, and 72 percent of them said that they would at least try to set up these contracts with some of their existing patients.

We don't know if it's one patient or all of their patients, but there is some potential there for disruptions

in that regard.

DR. CURRERI: Did any of these doctors indicate that they actually had a contract?

MS. SCHOENMAN: No, not to my knowledge.

DR. CURRERI: I don't see that contracts will come to fruition. I really don't think it's worth it.

DR. ROWE: It certainly seems to me that the question that hit the target right on the bullseye is Ted's question about what is, in fact, the phenomenology of this attempt to reduce their costs, and what if any implication does that have on access. I think that that would be a very important question. It's really the next question after what Gail says, if we learned that they're still providing the services and they're trying in other ways to reduce their expenditures.

Then the next question is, well, are those other ways likely to reduce access to beneficiaries, which is, I guess, should be one of our concerns.

DR. WILENSKY: The problem is going to be that answering that, for the most part, gets into some very subtle differences. Ted had raised the question of, do they

change what they pay individuals or did they change the number or did they change the mix.

And if they change any of those, what does that mean. I mean, if you're using a nurse practitioner versus another type of health practitioner, what does that mean?

DR. ROWE: The people to ask would be the patients of these doctors during this time in which the physicians are reducing their expenditures in a way and if we could get to those patients in some way and say, you know, have you noticed a difference? Now, most cardiac surgeons don't operate on the same patient more than once within X number of years, or orthopedists or ophthalmologists, but some do.

Certainly for the non-surgeons, I think you would be able to get some data. It would be nice to match what we think are the physician behavioral changes with the perceived impact on the part of the beneficiaries.

DR. CURRERI: I'm even more concerned about the attempts to increase revenue because there's study after study showing that as you increase diagnostic services, for instance, you improve diagnosis until you get to a certain point and then it plateaus out and then finally, if you do

too many, you start causing complications.

If these increases in revenue are increases in inappropriate diagnostic testing, that may be -- if it's the other side of access, it's too much access and it may end up --

DR. ROWE: Well, overuse is as much a quality problem as underuse.

DR. LAVE: I'm thoroughly confused. I thought we had done this survey as trying as a way of getting a quick feedback as to whether or not, in fact, it looked as if these decreases, a significant decrease in revenues was having any major impact. I thought that that was the reason we did it and I thought the reason that we asked them to focus on ophthalmology, cardiology, and orthopedics is that was where the big decreases were.

I guess that I looked at this and I think that there's not much in here that would leave me too much concern. I mean, you're talking about increased revenues, but we see that they decreased revenues.

DR. ROWE: Why is that confusing to you?

DR. LAVE: I'm trying to make sense of this

conversation, where it's taking us, and it certainly seems to me that nobody -- it doesn't sound as an awful thing to have happened. People are still seeing physicians. None of them drop Medicare patients. They decreased their staff costs.

I don't know for ophthalmologists, cardiac surgeons, and orthopedic surgeons, if they do a lot of stuff in their offices, whether or not it's going to impact on the care that they give their patients.

DR. WILENSKY: It is, of course, exactly what we've been saying for the last several years, that hospitals have been able to respond to the lower Medicare payments because they've found ways to reduce their costs. And basically, we're saying that physicians who got hit with the change in reimbursement appear to be reducing their costs as well.

DR. CURRERI: Or shifting them.

DR. WILENSKY: It's hard to tell whether there are any bad things that go on. If you wanted to, you'd have to do a very detailed study to try to get a handle on exactly how they're doing it.

MR. SHEA: There might be access problems among the working population involved.

DR. LAVE: That's true, but I'm trying to sort of figure out how we can take this data and put it into the context of where we were going with it, and the big issue or concern that I thought that we had was the one on access.

As I read these data, it seems to me as if, in fact, the Medicare beneficiaries who are under HMO contracts are actually at more risk than the ones that are under the fee-for-service contracts in terms of how they perceive things like paperwork, costs, reimbursement that you think those are a problem. I don't know whether they are or they are not, but certainly relative to fee-for-service, the Medicare beneficiaries in fee-for-service don't seem to be that much at risk.

The other thing, though, it did seem to me was important was to take Ted's idea and to sort of say, this is one survey of four surveys that were done this year and do they give us a consistent story about what, in fact, is going on. That might be actually very useful.

DR. WILENSKY: And to the extent they don't, is

there any sense about -- was there something that says, well, we're talking either at different times to different physicians --

DR. LAVE: Or different designs or different questions.

DR. LEWERS: There's no way of knowing until you do that.

DR. WILENSKY: I think that would be interesting to do.

DR. MYERS: Two quick cautions. One is that all Medicare patients are not alike. Those with significant wrap-around coverage, there's evidence that they are treated differently than those that don't have that, especially with respect to variables that are controlled by some physicians.

We've got good evidence of that, as do others, so I wouldn't necessarily want to say that what we see here in fee-for-service is indicative of the entire spectrum of Medicare patients.

Secondly, that Medicare does not exist in a vacuum within a physician's practice and there's also evidence that I think some physicians, hopefully very few, compensate by

changes in practice patterns with respect to non-Medicare patients. I don't necessarily think that's what we would like to induce or ignore.

I think that we have to be cognizant of the fact that those kinds of changes do occur.

DR. KEMPER: I guess the one thing that I find striking is that if you ask physicians about concern about payment and look at the change in concern about payment, they're a little bit more concerned about payment under Medicare, but they're almost twice as much more concerned about payment in private insurance and about four times as much in HMOs.

So we're in the pack there in terms of that. These are perceptions; they aren't actual payments, but in terms of expression of concern, I guess that's somewhat reassuring.

DR. WILENSKY: And consistent with what the conventional wisdom is.

DR. LEWERS: Just a question which confused me that's not in your presented material and reviewing the charts. You had a question about, have you changed your

referral pattern in after-hours. I'm not reading this, but that's my memory. And yet, when I go through the survey that at least is in the blue and the orange, I don't find any questions relative to that.

MS. SCHOENMAN: I think there were two questions.

DR. LEWERS: Well, I missed them. I was wondering what you were looking for with that data as well. I wasn't clear on that.

MS. SCHOENMAN: There was question 11, which was asked about --

DR. LEWERS: Does it make any difference whether I grab the blue or the orange?

MS. SCHOENMAN: No, it does not. Not in this case.

DR. LEWERS: Thank you, because I spent an hour trying to figure this out.

MS. SCHOENMAN: Question 11 asks about difficulty referring patients for various different -- patients with different types of insurance, and we didn't present that analysis here.

DR. LEWERS: But that doesn't say anything about

after hours.

MS. SCHOENMAN: There's another question, 17(b) which asks about after hours. That's a separate table in the packet that you got.

DR. CURRERI: I just think there's one other caution that we need to take, and I'm looking at this graph on practice changes in response and it shows 50 percent of people are trying to reduce staff costs. I think this relates to, trying to figure this out, to what Ted was concerned about.

I think a lot of these reduce staff costs are shifting of the costs somewhere else. For instance, cardiothoracic surgeons are used to bringing around their own nurse to do the pre-op. They are now telling the hospital, hospital pay for this or I leave. The same is done for operating room scheduling that used to be done in the office is now done there.

So a lot of it is just cost-shifting from Part B to Part A.

DR. LEWERS: Some of it is. But when I go around and ask similar questions, have you laid off staff in the

last year, the answer I'm getting very frequently is yes, and more physicians, where they in the past had typed their records or made some sort of record, they're letting their transcriptionist go. They don't use them anymore. Some of them have actually reduced instead of increased their billing and are doing some of it themselves, which is a disaster.

So I think there is a change and I think there's another element that's here. I was in an academic center recently talking to them about their problems orthopedically, and hips are not a problem, they're paid for. But fractures of the femur are not recognized and are a problem, so they're shifting those. They're not doing those in the community hospitals anymore. They're shifting those individuals out.

So I think --

DR. LAVE: Is that good or bad?

DR. LEWERS: As Gail said earlier, it would take an immense detailed survey to find these things, but I think they are an example of a changing problem of access to care for individuals and I don't know how we get to that

information. We're not getting to it with this.

DR. WILENSKY: The fact is, a lot of times if we know there's a change, we don't know whether it's a good or a bad, as my neighbor here was saying. In some cases where you have more done with fewer inputs, you call that increased productivity.

DR. LEWERS: Private industry does.

DR. WILENSKY: What you can document are changes, and particularly there are some changes that we have a first level of concern until we can find others, and I think what this is showing us, at least in terms of participation in Medicare and willingness to see new patients, are a quick snapshot that indicates that isn't happening.

How patients perceive the change will come out of an analysis of the current beneficiary survey where we can get at post-BBA data, and when we see changes, if we see changes, it will take some spot detailed case settings to try to understand whether the changes that occur are neutral or different ways of using inputs are producing different mix of services that may or may not produce a different quality of health care.

But I think at least there's some initial assurance from this data. It would be interesting to pair it with other information that even in the face of what seemed to be substantial reductions for certain proceduralists, we are not seeing a change in the willingness to see Medicare patients, which doesn't surprise me because when I go around talking to physicians, what they say is Medicare is one of the best payers around.

So it's not surprising that we're seeing information that says yes, I'm still willing to see all or some new patients on Medicare.

DR. ROWE: I think the one thing we have to realize is that one of the factors that's going to influence -- we should not look at this data and say, the change or lack of change in a physician's willingness to see Medicare patients is related to the reduction in the Medicare payments. What we should do is also say, in that same physician's practice or in that market, what has been the change in HMO penetration during this period of time.

The fact is that these other things are changing more rapidly or greater, and so that's mitigating what we

would have expected to be the adverse effect of this. It would be nice to have those data if we could, particularly when you look at the HMO effect here, which quadruples the Medicare effect.

I mean, that's swamping the data. This is not a referendum on how doctors feel about the changes in Medicare. It's a referendum on how much worse the changes in managed care are.

DR. CURRERI: I think the same is true for the private because more and more private firms are using the Medicare fee schedule now with their own conversion rate, and that took a bigger bite than the Medicare did out of most physicians.

MR. MacBAIN: Again, to get back to what we were trying to demonstrate with this, I think, within the narrow world of Medicare, we can say that we can take some comfort that at least so far we haven't done any damage to access by the changes in the fee schedule.

But the other data, I think, are disturbing, that is the growing disaffection with their profession on the part of physicians. There was a study I read not long ago

of patients and physicians in one insurance company that had both capitated and fee-for-service payment modes spread over several cities.

Those patients whose physicians were paid on a fee-for-service basis, the patients scored higher on a test of trust of their physicians than those patients whose physicians were capitated, regardless of whether the patients knew how the physicians were paid. In fact, it even held up among those patients who misidentified how their physicians were paid, suggesting that something in the payment arrangement was getting through to the patient in a way that affected the level of trust as scored at least on this particular survey.

It's at that level of something that is affecting the quality of the interaction between the physicians and the patients that's going on universally, not just as a consequence of what's happening in Medicare that I think is a greater concern.

That's way outside the purview of this group, but if anything, I think where the survey shows something of interest, that is something beyond more of the same, it's in

that area that further documents this growing disaffection with their profession.

DR. LAVE: I guess I was trying to think of some sort of summary conclusion from I drew from this as well, and I guess that what I drew from this is that if one thinks of the overall population of physicians, is that the relatively speaking, that the Medicare beneficiaries seem to become relatively more attractive over time compared to the rest of the patient population.

Not necessarily in absolute terms, but certainly if you think the 1997 -- the comparison over time, so it is not to say that the practice of medicine has become -- there are problems, it seems to me, that this has indicated that physicians perceive with respect to the practice of medicine.

But if one thinks about how attractive the Medicare fee-for-service patient is in the context of the overall patient population, if anything over time, the Medicare fee-for-service patient seems to have become relatively more attractive.

DR. CURRERI: Unless they switch into HMOs.

DR. LAVE: I said fee-for-service. And that's what motivated this, was fee-for-service.

MS. ROSENBLATT: I just was going to comment. I want to sort of underline what Jack said, his point about how the HMO data is kind of overwhelming the study, and I think that there's -- it could be a leading indicator of physicians who are going to withdraw from Medicare risk plans.

I mean, there are a lot of implications aside from what the primary purpose of the study is that could be -- I mean, I was alarmed when I saw the rapid change in a short period of time.

MS. NEWPORT: Just a couple comments. I think on the reimbursement side, the data on the HMO payment doesn't surprise me. I think it's interesting, though, the conclusion you could draw from the problems with the clinical review and the paperwork side of it, which speaks, I think, on the clinical review to a higher level of requirements that have preexisted the BBA and have been amplified under BBA to do more quality review and the types of review.

So I think that does interfere -- we've talked about this a little bit before -- that how much is driven in into the practice setting in terms of having people come in independently and review charts and auditing of all that data which is going on in HEDIS and HEDIS Medicare.

Then the paperwork piece, I think, is really interesting. Just to share, we have a group in Denver with our company, who signed up with our company, who decided they were not going to take fee-for-service Medicare anymore because the paperwork burdens were overwhelming them on that side. They just wanted to take HMO managed care patients in Medicare.

Now, maybe they need to be subject themselves to further testing. I mean, that's a real outlier, I have to say. It is not a trend. But I thought that was fascinating in terms of, in this one area, the practice has made a decision to go just with HMO patients.

DR. WILENSKY: Alice, I'm going to go back to the comment you just made about the fact that the results were so much greater with regard to the HMO. That HMO was a combined Medicare/Medicaid/private HMO. So I think you

really ought not to assume that that says anything about withdrawals. There may be withdrawal issues, but you can't see them because of the data.

MS. ROSENBLATT: I understand that. I think there are definitely definition problems. My guess is that it's not just that there's active and -- that there's commercial HMO and Medicare risk HMO in that category because I think the word HMO says HMO and other capitated. My guess is HMO got the vote in that category.

DR. WILENSKY: The fact is that the Medicaid HMO population is so much bigger. So I just don't think you ought -- whatever that is a response to, Medicare HMO is not necessarily reflective of whatever is going on.

MS. ROSENBLATT: Good point.

DR. WILENSKY: Thank you. I think a lot of good comments.

Our next session is on access to home health services.

MS. BUATTI: In response to policymakers' concerns that the payment limits established by the BBA were making it difficult for home health agencies to provide necessary

services to Medicare beneficiaries, the Congress directed MedPAC to examine access to home health services for its June report.

Today I'd like to review the work plan that I presented to you in November and give you a status report on those items.

In preparing the June report, we plan to take a four-pronged approach to examining access. We plan to examine the supply of home health agencies and then to look at home health agencies' response to the interim payment system. We'll also examine use of home health services over time, and we hope to learn more about beneficiary perspectives on access to care.

The first project is an examination of the supply of home health agencies. Provider supply is a rough measure of access to care. One, adequate number of providers is necessary to furnish needed services. A decline in supply does not necessarily mean that beneficiaries are experiencing access problems.

We're planning to use agency supply to help us identify areas where there might be potential access

problems because of decline in supply. Doing that, we'll examine the number of home health agencies submitting Medicare claims.

We will compare the number of agencies submitting claims during the first six months of 1998 -- that's the latest period for which there are data available -- with the number of agencies that submitted claims in the same period in 1996 and 1997. We plan to present the results of that in April.

MR. MacBAIN: Louisa, will that be broken out by region of the country, urban/rural?

MS. BUATTI: Yes. Urban/rural, type of provider, all that.

We hope to get a better handle on home health agencies' ability to provide services for Medicare beneficiaries through a survey of home health agencies that we're conducting. Generally, the survey will provide us with information about agencies' understanding of the interim payment system and hopefully will tell us more about how the payment policy changes have influenced provider practices.

We contracted with Abt Associates to conduct the survey of 1,000 home health agencies. As of earlier this week, Abt had completed 920 interviews and we had a very high response rate. Since the commissioners received the mailing materials that we sent out last week, we have received some preliminary results from the contractor.

These results suggest that there's wide misunderstanding about how the interim payment system works and that a substantial number of respondents have indicated that they have changed their practices, either by changing the number and types of visits provided or by avoiding certain types of patients.

The third project that we're going to be doing in the next few weeks is an examination of home health use to see how it changes over time. Again, we'll look at claims data from January through June 1998 and compare utilization rates with the same period in 1996 and '97. We will present those results at the April meeting.

The final source of information for the report is an attempt to gain a better sense of beneficiary perspectives on access to care. We are hoping to learn more

about whether or not beneficiaries are indeed having difficulty obtaining needed home health care and we're hoping to identify underlying reasons for their access problems.

We'll do that by convening a panel of individuals familiar with home health care and beneficiary needs. We chose this option because of the difficulty of obtaining information directly from beneficiaries. We are going to be convening a panel of individuals representing beneficiary interests on March 22nd.

In selecting the panel, Abt Associates, our contractor, spoke with about 100 individuals in research, health care, legal aid, and advocacy fields to identify a group of 15 panelists. The panelists were selected based on their understanding or their familiarity with access problems as well as their geographic location.

From the panel, we hope to learn more about general home health access problems, changes in beneficiaries' ability to access home health care, and beneficiaries' ability to cope with access problems. I'm particularly interested in learning from the Commission

issues that you'd like the panel to address.

DR. WILENSKY: Let me ask you a couple questions. Yesterday, Murray may or may not have told you, as part of the Finance Committee hearing, we promised information on this issue to the Finance Committee. They have a high level of interest about what is going on in this area.

One of the things that I wasn't sure about is whether you will make any attempt to -- validate isn't quite the right word -- but to put in context the comments of the expert panel with what we see on the claims data.

MS. BUATTI: Yes.

DR. WILENSKY: It's always a little -- I think it's very useful to have to talk to people who are representatives of beneficiaries to see what they think is going on, that you will learn things you don't learn from other ways. But I'm uneasy if there isn't an attempt to validate through some other means whether or not their perceptions of what is going on appears to be consistent with what we're seeing some other way.

MR. SHEA: Is it possible to do that in a timely manner?

DR. WILENSKY: Well, you're looking at claims data from 1998, so that's at least post-BBA.

MS. BUATTI: Right, and the panel is meeting next week. There may be some effects of the policy changes that we won't be able to see or see the whole picture, but to some extent, yes.

DR. WILENSKY: So presumably their perceptions would also be basically '98 based? I mean, there might be a little '99, but their perceptions of what's going on will be from '98?

MR. SHEA: I think that's great if the data really is there.

DR. WILENSKY: Obviously, if it's not '98 data, then it won't be able to do it, and if we can't do it, then we just have to say this is what we're looking at. But to the extent we can try to get some sense about whether we're seeing what is being told through some other means, I think it will be much more powerful when we report it out to various committees.

MR. SHEA: When did the interim payment start?

MS. BUATTI: For cost reporting, periods beginning

after FY '98. Most of the agencies fell under the limits, though, starting in January of '98.

DR. WILENSKY: So the claims data actually ought to be picking that up?

MS. BUATTI: Right.

DR. WILENSKY: I think it's very important. This is really exciting information to have available.

DR. KEMPER: I'd underscore that. I mean, Bill Curreri is not here, but he's on a couple of occasions emphasized how important it is to have timely data and this couldn't be much timely. It's very fast.

I think it doesn't surprise me that the home health agencies don't fully understand the interim payment system. It boggles my mind. I think it would be useful if the chapter tried to have a clear exposition of that and use that focus where you look in the analysis to sort of where do you expect to see changes the most, what kinds of agencies and so on.

I guess the other question I had was, the interim payment system is the big thing that's going on or has gone on, but there's also the requirements of physician

reauthorization that Ted was talking about last meeting or meeting before, and also a lot more publicity and emphasis on fraud and abuse.

I guess my question is, is there any way of sorting those out or how are you going to deal with those things going on simultaneously? I'm not sure everything ought to be attributed to the interim payment system.

MS. BUATTI: In our survey questions we tried to be clear that we were talking specifically about the payment changes. In addition, in the contractor's discussion with potential panelists, we learned that there were -- people were concerned about a number of different issues.

In selecting the panelists, they tried to choose people who had specific knowledge about the payment. Now, we do intend to include discussions about the other policy changes that may be impacting this and sort of the difficulty in teasing out, for example, in utilization rates the exact source or the reason for the change.

DR. KEMPER: For the claims analysis, is it possible to divide agencies into ones where you would expect a big change in payment, medium change in payment, low

change in payment or something like that to see if there's any way of sorting out the changes by the magnitude?

MS. BUATTI: We could do that, but it's mostly by geographic region.

DR. LAVE: I had sort of two questions about that. First of all a thought and that is that it strikes me that one of the problems that people are having is the per-beneficiary limit, and it strikes me that clearly one seems to get the impression that this is perceived as being a cap as opposed to an averaging process.

So it might be interesting to sort of organize the things by what the beneficiary limits are to try to get a sense for whether or not that's going on.

The second issue that I had, there are things that you would really believe would affect the limits on this. I'm not sure what the incentives are to decrease the number of people who come into the system. So I would like to have that explained to me.

DR. NEWHOUSE: Incentives to increase if you're at the limit.

DR. LAVE: I would think they would increased, so

in terms of thinking this out, to get some sort of sense for why it is that one would believe that under the new payment system that, in fact, the number of people using the system should be decreasing, unless it's related to the areas where home health agencies have decreased. So it's an overall supply issue as opposed to a different use of new entries among the current thing.

The third thing that issue was, anecdotally, there have been some reports in the newspapers about changes in the home health services and physicians deciding because of the change in the services to keep physicians in the hospital longer.

The reference has been with respect to home health. I don't understand that incentive with respect to home health. I can't understand it with respect to what happened in the skilled nursing home area. I could think of some reasons why that would happen for SNFs because of the reimbursement changes, but not with respect to home health in terms of physician recommendations. So those are the three sort of puzzles that I have.

MS. BUATTI: To talk about the second one, we have

the sense that there are certain types of patients who are less attractive to home health agencies because they may be more expensive than the others, and that goes into the averaging of costs.

The reason that there may be fewer patients in the system overall may not have to do with the payment limits, but some of the other things that Peter alluded to, for example, a tightening on the eligibility requirements, patients who had received home health care purely for venepuncture are no longer eligible.

In addition, there's been some concern. This also, I think, relates a little bit to the third point you made, that physicians are concerned about referring patients to home health services because of stricter penalties they may face for inappropriate use of that service.

DR. LAVE: I was also thinking the fraud and abuse thing would come in here as well. But I think it would be very useful to have very clear-cut sort of model in the back of your head as you do this as to what the stressors are that one would think would influence X, whether or not it has to do with the reduction in the capacity of the system

or whether or not it has to do with physician behavior or patient behavior or home health agency behavior.

So one can begin to maybe have a better story. If you think about a priori rather that just sort of decide to think of it ex post.

DR. LEWERS: In the panel that's meeting next week, you talked about providers and associations -- how did you word it -- providers, legal aid experts, Medicare analysis, advocacy groups. Does that include representatives of the home health industry that are going to be on there or not?

MS. BUATTI: No. The providers are primarily geriatricians. I think we have some social workers.

DR. LEWERS: The only reason I ask, and I think this was all said in jest, but when I pushed they indicated it wasn't. I recently had the opportunity to give a talk on Y2K preparedness for the health care industry. I represented the industry, which scared me to death.

But I called around to a number of areas and said, all, what's the story and what's going on. I called the home health and they said, well, no, we're not ready and

we're not likely to be because as of BBA, we may not be in business in Y2K, and I laughed and thought that was rather ridiculous.

And the individual was dead serious and I don't know whether that is true, not true. I don't know whether we've surveyed the industry as to the impacts of BBA. It could change your survey completely if it does.

MS. BUATTI: Right. We tried to get a sense of the agencies' financial situation in the survey, if they were expecting serious repayments, if they knew their caps, things like that.

DR. LEWERS: So you are trying to look at something?

MS. BUATTI: We are trying to get a sense of that, yes.

DR. KEMPER: I assume that even though they might not be on the panel, you're obviously getting industry input into the nature of these impacts and so forth?

MS. BUATTI: Yes.

DR. KEMPER: On the anecdotal side or qualitative side?

MS. BUATTI: Yes. In addition, we met with representatives from the industry prior to developing the survey instrument to get a sense of issues that they thought were important to bring out, and we've had ongoing exchanges with them about issues that they're concerned with.

DR. NEWHOUSE: My question for you is, as we all know, this industry has incredible rates of growth in visits for those many years in the '90s, and the presumption, I think, up on the Hill looking at those numbers was that this has grown too fast. We didn't want to be paying for all of these visits, so they cut back and then they eased up a bit.

Now let's suppose we see reductions in visits. Then it seems to me the question is well, are those the visits that one wanted to see reduced, accepting for the moment the presumption that somebody wanted to see some sort of decrease in that total.

I'm not sure how this questionnaire lets us get at that. I mean, you have in one of your overheads, does this decrease needed home health visits. Well, I think in the beneficiaries' eyes, I could imagine that they would think it would be needed.

No physician I talked to seems to have a very clear notion of what is a needed home health visit or at least not in the same sense they have a sense of what is a needed medical service. So where are we here in terms of interpreting this?

MS. BUATTI: Well, it clearly is a difficult issue. I think we're trying to define it as services for which the beneficiary is eligible. In our discussions with the contractor --

DR. NEWHOUSE: We just got issued a report saying the Congress should clarify itself.

MS. BUATTI: Right. We did get a sense that, in some of our discussions, that, in fact, there were beneficiaries who were not getting as many services as they had received before. Some people told us that those were people who maybe weren't eligible for the services anyway, and then we've also heard stories of people who, in fact, are eligible but because the payment limits are so low, the agencies aren't able to provide what the person should be able to receive.

DR. CURRERI: In whose estimation, theirs or the

doctors?

MS. BUATTI: It depended on the source or the person's background who we asked. Again, this is from --

DR. CURRERI: The bottom line question here is, is the reduction of services overall good or bad, and I don't know the answer to that question and I don't know whether you're going to get the answer. If we're talking about that 5 percent that have 250 visits a year and they're reducing those down, is that good or bad? I don't know.

MS. BUATTI: We tried, in the survey, to identify the types of patients who the agencies weren't accepting any longer by different characteristics and we hope that will -- we actually allowed the agencies to respond however they liked and gave a long list of potential coding.

DR. NEWHOUSE: I saw that, but I didn't know quite how to answer Bill's question. But Spence had a hand up over here.

MR. JOHNSON: Just by example -- I know this isn't scientific data, but there's a Medicine in Health Daily article from a couple days ago that says it was projected that home health expenditures in '98 would be $20 billion,

and these expenditures ended up at less than $15 billion.

Then it talks about a CBO calculation error that said the effect of BBA '97 was to be $16 billion less between '98 and 2002, and the revised estimate that these reductions are going to top $47 billion from the CBO. So one might assume, without the benefit of the survey, just looking at the numbers that there must be several hundred thousand beneficiaries less getting home health services.

Now, it's another issue whether that's good or bad. This is just the financial numbers.

DR. WILENSKY: Although it may also be just different services that they're getting because the growth was really in both dimensions, twice the number of people getting services and of those getting services twice the number of services. So this issue, I don't know whether we'll be able to speak to that or not, but whether it is a lot fewer people getting services or whether it's similar numbers of services to people, but fewer services.

MS. BUATTI: We should be able to get a sense of that from looking at the six months of claims.

DR. KEMPER: We won't really know whether it's

better or worse, but by breaking it down by type of patient, length, and whether it's an aide visit or a nurse visit or a therapy visit, I think we'll at least get a sense of where it bites.

DR. CURRERI: Won't we get a sense of whether it's skilled nursing services or homemaking services or respiratory care services?

MS. BUATTI: Yes, we can look at the visits by type.

MR. SHEA: I assume that in the group, the panel that you convene, you're going to be asking about loss of services or the effect of loss of services and those kind of things. Are you also going to ask about any substitution?

MS. BUATTI: Yes.

MR. SHEA: Were there other sources of the service available?

MS. BUATTI: Yes.

MR. JOHNSON: I was just going to ask if there's going to be any way to tell in here any difference geographically, urban/rural?

MS. BUATTI: Yes, we plan to look at it by those

characteristics.

DR. WILENSKY: Any other questions?

We look forward to seeing the next round of data. Let me stop and ask for public comment before we go into our graduate medical education section.

VOICE: Are there any hospitals being surveyed or any home health agencies that were part of hospitals surveyed in this?

DR. WILENSKY: The question was whether or not home care agencies that were part of hospitals were in the survey and the answer was yes.

MR. CALLEN: Mark Callen, Health Care Association of New York State. I could probably talk for about a half-an-hour on IPS --

DR. WILENSKY: But don't.

[Laughter.]

MR. CALLEN: -- in New York State and the impact it had. In particular, ours concerned hospital-based home care agencies and I would just like to make a couple of points. First of all, part of the problem is that IPS is the interim payment system. The PPS should solve a lot of

the problems, but when you have a per-beneficiary limit that is not adjusted for severity cost of case, it inevitably leads to some inequities.

Part of the problem that we've had is that we're not quite sure how long we're going to be on the interim payment system. It is essential that we go to a PPS that will adjust properly or else we're going to see what's going to be happening in New York State and, I assume, a lot of other places.

We are beginning to hear about hospital-based agencies that are going to close or sell their agencies because the IPS per-beneficiary limit is causing them -- they just can't stay in the business.

I wanted to say something also about the study you're doing. You're looking at early 1998 data. The per-beneficiary limits did not come out until later in the year. Agencies in January and for several months thereafter did not know what the per-beneficiary limit was going to be.

The payments that they were receiving from their intermediaries were, in essence, unchanged. Just within these past two months, our intermediaries asked for cost

report information from our agencies so that they could determine what the payback was going to be.

It is only right now in New York that the agencies are actually being hit with -- they're going to have to reimburse for the overpayments they received last year. I guarantee they did not understand the full impact in the early months of 1998.

I do not think you're going to see, in the claims data, the full behavioral impact of IPS. I believe that there will be a dramatic impact in terms of utilization of services, whether it's the way you want it to be or not, and I do think you're going to begin to hear about agencies, not the type of agencies that you may have been thinking about going out of business.

DR. WILENSKY: As you know, our data goes through July of '98. Obviously that is as late as we can get it. There's no way we're going to be able to get data about what is contemporaneous in its events, but as soon as we are able to get later data, we'll obviously do so and any data that New York or other groups can provide us, we will certainly look at.

DR. NEWHOUSE: One of the things that has puzzled me about the response, which I hear from places other than New York, about the per-beneficiary limit is that it seemed to me if I were running a home health agency and I were bound by this per-beneficiary limit, I would be making an effort to increase my services to like users and make the limit not binding.

I'm curious as to why we're not seeing this kind of response.

MR. CALLEN: I think on the hospital side, one of the problems that you have is the nature, the type of visits, and I would suggest that while some of the patients who come into hospital-based agencies may require a shorter period of treatment and therefore fewer visits, during that period of time, they may be much more expensive.

I don't think that at least on the hospital-based side that they can very readily change the types of patients that they're treating. Part of the problem is that the 1993 base year that was used to determine the per-beneficiary limits and then was reduced by 15 percent, that base is so low that even though they may be trying to do what you're

suggesting, having patients that have lower costs or fewer visits, they're not able to do it sufficiently to stay solvent.

But I would expect the same thing that you're saying in some of these areas where you have an average of 100 or 120 visits per patient. I would expect that that would happen. I think you're going to see different results in different parts of the country and different results by free-standing or hospital-based agencies.

DR. WILENSKY: Thank you.

Let's go to our last session on graduate medical education.

MR. LISK: Good afternoon. It's getting late, but as with how everything has gone the rest of the day, we're going to try not to keep you bored. You've been very active, so we hope you can stay active at this late hour for these discussions on graduate medical education and the indirect medical education payments Judy will be discussing.

The challenge for you today is to start making some decisions on recommendations and direction for the Commission as you believe the policies and where you want to

go for the upcoming August report. The material for your discussion today is in Tab G.

For my part of the discussion, I'll provide a brief refresher on Medicare's direct GME payment. I'll also go over the principal issues the Commission needs to address for its report. We will then discuss some potential broad-level options for changing the current payment.

Then I will review an analysis of the potential financial impact of a set of illustrative options that we have examined. Then I will lead you to discuss where you want to go with the potential recommendations.

To review the payment, direct GME payments are made out to hospitals based on their hospital-specific costs per resident in a base period, which was 1984 for most costs updated by inflation. Now, Medicare does not pay its full amount at this amount, but it pays its share of the amount based on Medicare's share of inpatient days.

There's also waiting factors involved with the resident caps, for subspecialty residents are counted less, and also starting with the Balanced Budget Act, there was a hospital-specific cap that was placed on the resident

counts. So program payments no longer grow with the growth in the number of residents.

In addition, payments are based on a three-year average of a hospital's weighted resident count, which helps partially shield hospitals from the full revenue impact if they reduce the number of residents they train over time.

There are several basic issues that the Commission needs to consider as it discusses how Medicare's direct GME payments might be changed. First, what should Medicare or the federal government's role be in paying for GME? Questions you need to consider here include, should Medicare or the federal government be supporting these expenses or not? Is there a need for broader mechanisms to support these costs?

The second issue concerns what costs should be supported, and here you need to consider whether we should be supporting the net cost to hospitals or providers or the full program costs related to these educational activities, or some other form of cost in terms of what you think might be a reasonable payment if you think these costs should be supported.

If you pay for these expenses, you also need to consider what type of variation should be recognized. Currently we recognize hospital-specific variation in costs that are 15 years old updated for inflation. You may want to consider how this policy relates to other Medicare policies if you want to recognize these expenses. In most settings now, Medicare is paying more on a national rate rather than an institution-specific rate.

The third issue you need to consider concerns who should be paid if we think we should continue supporting these expenses. In considering this question, you need to consider who incurs the costs; who sets up and runs residency programs, for instance; who has control and who makes those decisions for flexibility.

Currently Medicare basically pays only hospitals, although the Balanced Budget Act expanded that slightly. You also need to consider what potential incentives may be created in terms of who is paid.

Finally, you also need to think about how payments should be distributed. Here the big issue to consider is the integration of the work force issues with Medicare

payment policies or whatever broader payment policies you might have. So how should payments be used to potentially influence the position or resident work force, and also to consider whether the current mix of incentives in the current Medicare program might be appropriate.

In the context of these issues, there are three general concerns often mentioned with these payments. One is the payments potential influence on the physician work force and where residents are trained. The fact that we have the payment may help to influence the number of residents that are out there, increasing the number of residents more than we might want otherwise.

Another is the wide variation in the per-resident payment amounts across hospitals, and you've often seen this information. We've displayed that graph often. And a third is Medicare's role in being the only explicit supporter of these expenses nationwide.

Here there's a continuum in terms of thinking about this. On one hand, you say you could think of it as why should Medicare be involved in this. We don't support these activities in other settings.

On the other end of the spectrum, we can think about this as the competitive market forces are making it more difficult for providers to potentially provide these types of services and support these expenses, so there may be something that's needed more broadly than what we currently have. So there's a continuum to think about there.

So for today, there are several broad options that we could consider for changing Medicare's direct GME payment. Medicare can continue its support, but we could consider modifying the payment in several ways such as moving to a national payment amount and making other modifications to the current payment.

We could remove the payment from Medicare and move to either funding these types of costs through appropriations or some form of all-payer trust fund, or we could consider eliminating the payment.

So after you consider these broad options, there are a whole bunch of level of suboptions and more detail that you probably would want to consider in terms of the types of recommendations that may be more specific that

you'd want to consider.

So there's three basic options that we're going to look at in terms of the analysis we did today and in terms of impact analysis on hospitals. One is the effect of eliminating the payment on hospitals; the second is moving to a national payment outside of Medicare where we redistribute the payment evenly on a per-resident basis across all hospitals; and then the third is within Medicare paying a national payment rate that's wage-adjusted.

So you'll be seeing just shortly those effects. But I wanted to first show, just as a reminder, what the variation distribution of payments and stuff are for these expenses. As you see in this overhead, academic medical center hospitals account for 10 percent of all teaching hospitals, and academic medical center hospitals are those that either owned by a medical school or have very close relationships to the medical school. These are mostly our big research teaching hospitals that we think of.

AMCs train about 44 percent of the residents, but they receive about 36 percent of Medicare's direct GME payments. Other large teaching hospitals which in this

analysis are hospitals with more than 100 residents --

MR. JOHNSON: Just before you start this chart, large, moderate, small, what size hospitals are you talking about?

MR. LISK: That's just what I was going over here. The other large group is more than 100 residents, but they're not AMCs. Moderate is between 25 and 100 residents and small are less than 25.

MR. JOHNSON: I was thinking of the size of the hospital.

MR. LISK: They range in size. I mean, the larger AMCs generally tend to be even bigger on bed size, but there are some smaller hospitals that have only a few residents that aren't as big, but there is a relationship there between bed size.

DR. MYERS: In other words, size isn't the size of the hospital?

MR. LISK: It's the size of the residency program here, yes.

DR. LEWERS: Say those again. What was moderate?

MR. LISK: Moderate is 25 to 100. But as you see,

in terms of most of the teaching hospitals have less than 25 residents, but they only train 7 percent of all residents recognized by Medicare.

DR. LAVE: Don't you think it's strange that the academic medical center -- I mean, the relationship between the percent of residents and the percent of GME payments between AMCs and other large hospitals seems a little strange.

MR. LISK: Go to the next overhead and you'll see partly why this is the case. First of all, this is the average per-resident payment amount. That's the updated amount, updated per-resident cost from 1984 updated for inflation, which is lower for AMCs relative to other hospitals.

If you look at what Medicare's actual payment per resident is, that's accounting for Medicare share, you see that they have a much lower payment. So there's a combination there that's going on. They have a lower per-resident -- average per-resident payment amount. They also have a lower average Medicare share.

There are about 30 percent Medicare patient

share; 32 percent versus 40 percent for the all teaching hospitals on average.

If we move to the next overhead, we can also see the average Medicare payment per-resident is substantially lower for public hospitals relative to the average for all hospitals. But we also see a difference here between the public municipal hospitals, mostly the city hospitals, versus public other hospitals which are state-owned hospitals on the average per-resident payment amount.

You see that that per-resident payment amount is actually much lower on the public others. Again, that may be partly accounted for because of state subsidies that are not -- they're being paid to reduce what the cost to the Medicare program is or the cost to rather hospitals.

DR. CURRERI: Craig, could you tell me, what is all included under the average per-resident payment amount? Salary and then what else?

MR. LISK: Salary, benefit, physician supervisory costs, allocated overhead to the hospital, other direct expenses related to the training program.

DR. MYERS: Based on the 1984 baseline?

MR. LISK: Based on the 1984 costs updated, right.

DR. LEWERS: Inflation adjusted.

MR. LISK: Right. And the interesting other thing on this chart is to look at children's hospitals where you see what they're getting from Medicare is about $420 per resident and that's because, of course, they don't have many Medicare patients in those institutions.

So if we move on to the next slide, we can look at what the impact, static impact would be on eliminating these payments in terms of total revenues. If we eliminated Medicare's direct GME payment, it would have a substantial effect on teaching hospitals revenues. Medicare direct GME payments would, of course, disappear for everybody in aggregate Medicare revenues, and when we talk about Medicare revenues through here, we're talking about which include both inpatient and outpatient payments to the hospital.

The teaching hospitals would fall by about 3.7 percent and total revenues would fall by 1 percent for teaching hospitals in the aggregate. If we look at academic medical center hospitals, though, they would see the biggest effect with a 6.5 percentage point drop in total Medicare

hospital payments, and a 1.6 percent decline in total hospital revenues.

If the payments were eliminated, 6 percent of teaching hospitals would see total Medicare revenues fall by more than 10 percent, and about 11 percent of the hospitals would see their total revenues drop by a little more than 2 percent. Generally that is in an error range. There's not many that go over 4 percent in terms of the total revenue decline in terms of the hospitals. It's less than 1 percent that have more than a 4 percent decline in total revenues.

Now if we change the current payment and moved to a national payment rate, and this is the equivalent of paying, given our simulations, $24,295 per resident, no adjusting for Medicare share, just an even amount per resident, this is just redistributing the Medicare monies, let's say, on a national payment rate if that was decided.

We would redistribute about 24 percent of total direct GME payments across hospitals. A little more than half the hospitals would see, in this case, would see payments reduced and a little less than half would see payments go up.

Overall, academic medical centers would see a 23 percent increase in aggregate in their direct GME payments, a 1.5 percent increase in total Medicare revenues, if we continue to count this as Medicare revenues. I mean, technically, it wouldn't be Medicare revenues, but just for the chart's purposes, that's what that is.

And a .4 percent increase in total hospital revenues. In the other type of teaching hospitals in this group, in terms of the smaller teaching hospitals, in aggregate, would see declines in their revenues.

The next chart, though, shows our public group and the children's group. As you can see, there are even bigger redistributed effects for the public municipal and public other hospitals.

MR. SHEA: I'm sorry, Craig. I just realized something. The phrase rate outside of Medicare means what?

MR. LISK: It's the equivalent of, if we just established an appropriation using Medicare money in its appropriation we gave the equivalent of $24,295 per resident to each hospital, each resident in the hospital.

MR. SHEA: Not as part of Medicare payments?

MR. LISK: Right. But when I look at the Medicare payment impact, I'm still counting it as Medicare payment impact here.

DR. KEMPER: So am I correct, Craig, you're doing two things. One is you're getting rid of that big distribution in payments?

MR. LISK: Yes.

DR. KEMPER: And you're also getting rid of the fact that it depends on how many Medicare beneficiaries you have at the same time?

MR. LISK: Right, absolutely. So as you see here, it would go up about 74 percent. Medicare payments would rise about 3.5 percent, and the total hospital revenues would increase on the order of 6 to 7 tenths of a percent.

DR. LAVE: I have a question about that. When you distributed whatever it was, $27,000 --

MR. LISK: $24,000.

DR. LAVE: Okay, it's $24,000, and you were distributing -- that's a national payment amount?

MR. LISK: No, that's the national average Medicare payment per resident.

DR. LAVE: That' the national average Medicare payment. But when you distribute that on a per-resident basis across all residents, each resident gets how much money?

MR. LISK: Each hospital gets --

DR. LAVE: It has to be less than that because you're giving more residents money.

MR. LISK: No. We're not including the VA and Defense in here, so this is the same residents that we're currently counting.

DR. LAVE: But it can't be because you have the children's residents are now getting the same.

MR. LISK: No, but the children's hospitals already get some. Because of the ESRD beneficiaries, children's hospitals generally have a couple of Medicare cases.

DR. LAVE: Okay. So all the residents get a little bit.

MR. LISK: Yes. I mean --

DR. WILENSKY: It's the same population. It's just redistributing the money.

MR. LISK: We may be underestimating actually the children's hospitals a slight bit. We may not have cost reports that have residents, but we have a substantial portion of them, I believe.

DR. LAVE: So we have the same residents in both cases, it's just that they get different amounts?

MR. LISK: The data we have shows we have about 4 percent of our residents in children's hospitals that Medicare supports.

DR. MYERS: With respect to children's hospitals, is ESRD and some security disability is anonymous? These are the kids that are --

DR. NEWHOUSE: No. That's how they get into here, because there are two different routes in here.

DR. MYERS: So there's two separate routes, I believe.

DR. NEWHOUSE: Yes.

DR. MYERS: And the relative proportions, is it mostly --

MR. LISK: I don't know.

DR. NEWHOUSE: Because you have to work before you

can be eligible for SSDI, then you have to be 24 months past the time you're disabled.

MR. LISK: But anyway, as you see, there's a substantial increase, of course, in children's hospital payments of more than 5,000 percent and that would increase their revenues, total revenues by 1.2 percent.

Now, the distributional impact of this option would be somewhat different if the national payment amounts were adjusted by, let's say, the hospital's area wage index. The proportion of hospitals that lose revenue would fall from 53 percent to 42 percent, and the loss of revenues realized by hospitals, let's say, in New York State would be cut in about half of what it would be otherwise. So there's some redistributed effects really more across areas when you adjust for area wages, as you would expect.

DR. CURRERI: But it would still shrunk the range of differences?

MR. LISK: Yes, it shrinks the range of differences. The one effect is hospitals in California's rates would actually increase because the area wage index is high in California. And it's possible -- we used here, the

hospital area wage index, it would be possible to create in the future a resident wage index based on the data HCFA is now collecting to make future changes in how they do the wage index.

DR. CURRERI: Could you give us some idea between the slide you showed us before, which was the national uniform rate, and this one as to, the first one where you just have a national rate not rate adjusted would shrink the rate how much?

MR. LISK: I'm not sure.

DR. CURRERI: Give me a rough guesstimate. Now, as I understand it, the range is something like $30,000 to $200,000, is that right?

MR. LISK: You mean in terms of wage adjustment, in terms of what the range would be for the average payment?

DR. CURRERI: You would shrink it much more without a wage adjustment, right, if you just --

MR. LISK: Well, without a wage adjustment, it's gone, there's no variation.

DR. CURRERI: That's right. And with a wage adjustment, how much -- what would the range likely be, by

half?

MR. LISK: I mean, with the wage adjustment it's about 50 percent higher --

DR. NEWHOUSE: But you'd probably adjust residents' salaries, which are much less variable.

MR. LISK: The resident's salary, yes, is much less, and actually, New York City might be benefitting because I think their relative wages for residents may be higher than their hospital wage index, and California's wouldn't go up as high if you had the resident wage.

But I'm trying to think, the highest wage index adjustment is currently 1.57 or something out in California and we're talking about here where teaching hospitals are, though. So it's going to be a little bit different than what the distribution is for PPS hospitals.

DR. CURRERI: My last question is, why choose wage adjustment rather than a cost of living adjustment?

MR. LISK: We don't have a good other alternative cost of living adjustment factor to use for area differences. We could. I mean, we could look at alternatives to use there.

DR. CURRERI: Because wage adjustments have some artifacts in them. If the area is heavily unionized, et cetera.

MR. LISK: I agree. But it is possible. It would be possible to do a resident wage index, I believe, in the future, given HCFA is requesting that those salaries be reported as part of their wage index survey, as well as the physicians salary so they could have some combination of the two.

If we move on to our final option we examined and that was to pay a wage adjusted national rate inside of Medicare and this one we're showing here is the wage adjusted one. This option would redistribute about 12 percent of Medicare direct GME revenues across teaching hospitals, half the redistributed effect of the uniform national rate.

DR. CURRERI: Where do the AMCs come in here?

MR. LISK: The academic medical centers here?

DR. CURRERI: Are they distributed throughout these different hospitals?

MR. LISK: No. They're only in that one group.

That's why the other large was removed from there.

DR. CURRERI: I'm sorry. I'm on the wrong one.

MR. LISK: The redistributed effect here is actually much smaller. As you see, it's 6.9 percent for total direct GME payments compared to what was 23 percent in the previous slide. Medicare payments in aggregate for AMCs would be up about .4 percent, and total hospital revenues .1 percent.

In this option two, it's about 39 percent of the hospitals would have their payments reduced and 61 percent would have their payments increase.

The effect on public hospitals is different here from the previous slide. Municipal hospitals would actually see in aggregate their GME revenues drop by 7 percent compared to 12 percent rise in revenues for the other public teaching hospitals, which are generally the state-run hospitals.

And again, this is due largely -- the other option benefitted the public municipal hospitals because of their low Medicare share and Medicare share not be accounted for. You still see a large increase in children's hospitals

payments here, but that's really inconsequential because their payment would actually be up from 400-and-some-odd dollars to $670.

Under this redistribution, less than 2 percent of teaching hospitals would see total revenues drop by more than 1 percent, so it's a much smaller effect on those hospitals. And if you look at those hospitals and see who they are, there are prestigious institutions at both ends. There's nothing that can -- I can just say, there are prestigious institutions that are at both ends of the spectrum in terms of who would win and who would lose under a proposal like this.

So with that, I want to return back to our major issues slide and have you go on with some discussion and potential direction for us and potential decisions on recommendations regarding the three broad areas that I had outlined.

DR. NEWHOUSE: Reading this, I had what I thought was an epiphany, but you may think it was merely a nutty idea. I started out from theory in economics of on-the-job training, which is pretty widely accepted and has a

basically simple idea, which is if you are getting training that is useful to you anywhere, the employer has no incentive to pay for it, as contrasted with say training that's going to be useful at that specific firm.

So it is generally accepted, I think, that for that kind of training -- this goes obviously way beyond the medical area -- that the person being trained bears the cost of the training in the form of lower wages, or sometimes may even have to pay for the training.

So apprentices get less pay than senior people. It seems to me that this is the situation with residents. Residents are getting trained, training they can use anywhere in the country, not just at the specific hospital they're being trained at.

We know they also get lower wages than attending physicians get and they're delivering services and presumably, if one thinks about why are residents' salaries where they are, the hospital or the hospital marketplace more generally is balancing the cost of training them, having supervisors and so forth and so on, against the services that the residents are delivering.

Now having gotten to that point, what that means is then -- now I have to go back in history. Initially we started off with paying hospitals cost-based reimbursement. We then, in '83, go to prospective payment and because we think that hospitals are producing training and producing patient care, we identify a class of costs we say are training. We break those off and we pass those through.

Then we still have teaching hospitals being more expensive for patient care, even after we net out these so-called training costs, and we say we want a level playing field for teaching hospitals, for all hospitals, otherwise teaching hospitals would get creamed by PPS, so we put that over in indirect and that's the rationale for indirect.

Now, if my reasoning is right about training costs, that was a flawed piece of logic, that there were no training costs of the sort that appeared on the Medicare cost report; that all of those costs were, in fact, patient care costs.

Therefore, what we should have done was instead of having direct program at all, having not take out the direct costs, count them as part of the cost per case that we were

using on the indirect side, and handle this all through the indirect side.

So that for the moment at least, until someone wants to tell me it really was a nutty idea and not an epiphany, my answer to your question is that we should move what we're now calling direct to indirect and reestimate the regression that we have on the indirect side.

MR. LISK: I've thought about that in the past as well. I never did the regression.

DR. CURRERI: Epiphany one and epiphany two.

MR. LISK: But I haven't thought about it real hard. I think it's an interesting concept, but I think one of the aspects of where the resident's services are a combination of two different types of things, though, and I think that's what calls into question whether you want to include it on the indirect because many of the services are physician services, which are patient care services, so that would be reflecting a combination of those two services.

DR. NEWHOUSE: Let me go on because there is the undeniable empirical fact that teaching hospitals are more expensive and the issue is why are they more expensive. My

answer to that is there's some combination of -- they product a different product. That is, for the same patient, the fact that the patient has an arrest at 2:00 a.m. and there's a resident there probably means the course of treatment is going to be different than if the nurse calls up the attending at home.

That there's some unmeasured case mix differences probably and there's, I think, some cross-subsidies to clinical research. This comes in more on the indirect discussion. I don't think in the PPS context, because we're paying a lump sum, that it should be inefficient.

But the important point here is it's not training, per se. These are costs related to patient care. And we've decided, implicitly at least, I think, we want to pay for them.

DR. KEMPER: Joe, can I just ask about your epiphany? Is that a constant budget option or does that depend upon the regression results?

DR. NEWHOUSE: It's obviously not a constant at the institutional level, but at the macro level, I think the first order of -- I mean, I haven't run the regression --

the first order of effect would be that it would be approximately budget neutral.

DR. KEMPER: Would you constrain it to be so in the end?

DR. NEWHOUSE: I don't know that you even have to. Forget the regression for the moment and just say all teaching hospitals were kind of up in one clump and all non-teaching hospitals were down in another clump, so we didn't have this resident ratio and regression and we just said, in that case, we'll pay the mean to teaching hospitals, their one peer group will pay the mean for non-teaching hospitals there, another peer group like we do with the urban and rural.

In that case, what would happen would be the direct would just come over and it would go into the mean of the teaching thing and it would go up by -- all of those dollars would just go over there. So I think that, as I say to a first order of proximation, it's going to be budget neutral.

DR. KEMPER: That's what I thought. If we did that, that answers some of these fundamental questions in a

very clear way.

DR. NEWHOUSE: That was what I thought.

DR. KEMPER: It really looks very much like the options that we looked at before, and we're really just looking at redistributional effects, the ones where it was simply redistributional across facilities.

DR. WILENSKY: But why would you assume budget neutrality?

DR. KEMPER: Because you're taking the direct costs and throwing them up in the --

DR. NEWHOUSE: I'm sorry, there's the issue of the so-called empirical payment level in the IME side, so that when we get to IME, things are not necessarily going to turn out to be budget neutral, but the effect of moving direct over to indirect should be to a first order.

DR. CURRERI: Would it be some amount multiplied by the number of total residents?

DR. NEWHOUSE: That's where we get into --

DR. CURRERI: Because what happens if somebody drops half their residents?

DR. NEWHOUSE: Well, that's where we get into -- I

think there's certainly issues on the IME side of how we distribute this, and we've chosen to distribute it by the number of residents per bed because that tracked the costs pretty well. That had the side effect of putting a bonus on every resident's head and having hospitals go beating the bushes for more residents.

But that was kind of an unintended side effect of the fact that we decided to measure how much -- how these excess costs distributed themselves across hospitals by the number of residents.

As I say, if the teaching hospitals all kind of clump nicely together instead of being distributed all over the place by the number of residents they had, we wouldn't have done this number of residents thing. We would have just paid them being a teaching hospital.

DR. CURRERI: Is that what you're proposing now?

DR. NEWHOUSE: No, no, no, no, no. I haven't come to the how we distribute. I'm just saying in terms of the rationale for direct, the original rationale was flawed. People looked around and said, the costs of training -- well, let me put it another way. The intent of the indirect

was to put teaching hospitals on an even footing with for-patient care costs.

People said to do that, we need to pull out the costs of training and just pass them through. Then what's left we'll put on an even footing. Well, if that's already knitted out in the residents' salaries, then there are no costs to put up.

Meanwhile, the accountant people went through and said, as Craig said, costs of resident, cost of training director, that's all training costs, we'll pull that out.

DR. CURRERI: I agree with everything you say thus far. It's the next four steps. How do you design it?

DR. NEWHOUSE: But I should say to that, that the incentives to go out and beat the bushes for residents, I haven't done anything with that, but I haven't made it worse either. I mean, the direct med ed already has those incentives in it because I'm paying a bonus per-resident.

MR. LISK: One of the things to consider is, in terms of what Joe is talking about, is you're talking about the provider cost in that case versus one of the other issues we talked about is what costs you want to recognize

versus it being the provider cost or training cost, program training cost, which are different matters because it's the cost to the hospital in terms of what is being talked about here.

Those things actually are different, so that's an important point to consider, because if your purpose is wanting to pay for the training costs versus the higher costs of teaching --

DR. NEWHOUSE: No, not of teaching.

MR. LISK: Of patient care. It's a different matter because in some cases, you're having states subsidizing or the residents are in other settings, so we're talking here, on the inpatient setting, and maybe something equivalent you'd want to have also on other settings, too, to where residents go.

DR. CURRERI: I think he's saying that the training costs are already accounted for by the --

DR. NEWHOUSE: What we write down on the Medicare cost report, those costs are already net of training costs.

MR. PETTENGILL: The per-resident amounts that you see on GME vary hugely across the set of hospitals you're

looking at. The reason they do, the main reason they do has to do with the historical financing of the graduate medical education program. I think that's basically what Craig is getting at.

To think that all of the costs that are captured in the hospitals' accounts are really representing patient care costs, I think, is wrong. What you're reflecting is the way costs were divided up among hospitals and medical schools.

DR. CURRERI: In 1984.

DR. WILENSKY: I agree with that, but what he's saying, a reasonable rationale is to look at this in terms of what's going on with regard to patient costs even though that wasn't how we started it.

MR. PETTENGILL: But then you have to reconstruct -- in order to get the amount, if it's all the same regardless of who is paying it, the hospital, the medical school, or whoever else finances it, in fact, the practice plan, then you have to go in and say, okay, we've got one hospital here whose resident amount reflects a program that is completely funded by the hospital.

We've got others where most of the funding is, in fact, in the medical school, so you'd have to recapture all of that to figure out what to add to your patient care expenses.

DR. NEWHOUSE: Not if I want to assume that the medical school subsidy is going to continue.

MR. PETTENGILL: But you're not measuring the same thing in different places then.

MR. LISK: That's right.

DR. NEWHOUSE: Actually the hospital that gets the medical school subsidy is going to be better off at the end of the day with my scheme, but I think it probably already is just because it's getting that.

MR. PETTENGILL: Only if it gets the average subsidy, better than average subsidy.

DR. NEWHOUSE: I think it's better off because of the way the indirect works and I think it's better off because of the way the '84 stuff works. But I think that's a second order. I think it's important to answer these questions in terms of what are we trying to do here. I think it's important to be clear about what these costs are.

MR. PETTENGILL: I'm not sure they're all patient care costs.

MR. LISK: I mean, that's right. It's a question of what we're allowed to include as costs in the base, going back into Medicare, what they were allowed to include and consider as costs related to -- educational costs related to the training of residents. Some of that is classroom space and --

DR. NEWHOUSE: First of all, these are going to be mostly small, I suppose, when I get to total overall cost per case, I think.

DR. WILENSKY: And besides, I think at some point, it's getting to be getting 20 years back how much are you going to allow yourself to be held hostage.

MR. LISK: The other issue on the budget neutral point, though, is there is a difference between what is the per-resident payment amount and what Medicare's share of that cost is versus what hospitals report now as their total costs for residents, and there's a substantial, pretty substantial difference, as I think it was about $68,000 is about the average updated per-resident payment amount is,

but the -- I'm remembering right now what the median per-resident cost is, it's about $88,000 today.

DR. NEWHOUSE: And?

MR. LISK: I'm just saying, in terms of what the costs are versus what current payments are in terms of the budget neutral issue that you had raised before.

DR. NEWHOUSE: By budget neutral, I just meant budget neutral with respect to the Medicare budget.

DR. KEMPER: I think Craig is saying that the difference between the $24,000 and what that number would be if estimated on today's costs rather than '84 costs updated, it would be a lot bigger number.

MR. LISK: It would be higher.

DR. NEWHOUSE: Oh, I see.

DR. KEMPER: So it's not budget neutral in that sense, although you could make it budget neutral if you wanted to.

DR. NEWHOUSE: I think we've got to carry on the discussion, because I think if we can agree conceptually, then we can come to this kind of answer.

DR. KEMPER: So you're saying yes, Medicare should

pay for GME, but it's really the additional patient costs that should be supported; stick with the hospitals, not other training settings; and that the payments, are you saying they should be still related to per-resident?

DR. NEWHOUSE: I have to come to how Medicare pays in the other settings when we get to the other settings. I mean, I haven't thought that fully through, but in terms of the original rationale for PPS, it was that the DRG payment would be, as I say, level the playing field for non-teaching and teaching hospitals for inpatients for what the DRG was paying for.

DR. KEMPER: So if people are being trained in plans, presumably if there are higher costs associated with that?

DR. NEWHOUSE: Well, that should pass on through to the residents' salaries that way.

MR. MacBAIN: I'd like to back up one step just to try to, at least in my own mind, put this in context, and that is, where are we trying to go with this? Let's say that we follow Joe's epiphany and solved the problem of how to allocate IME. What do we have as a result?

What problems have we solved by lumping the two together? What is it other than the congressional mandate to look at this that brings us to this topic anyway? Are we concerned about too many residents, too many physicians, too many physicians in the wrong specialties, too many foreign residents, too much money being spent?

DR. NEWHOUSE: I think we are concerned about the incentives that have been clearly acted on to hire more residents, but that's -- we've got to come at that problem some other way. One of the things you get out of here is, I think, well, if this is training, it ought to go to general revenue.

Well, if it's not training, if it's really patient care, then it's really part of Medicare patient care costs.

MR. MacBAIN: Which is where we started.

DR. WILENSKY: It really is saying that this is the cost for providing patient care in these settings.

MR. MacBAIN: Why do we want to change the current system? I'm not saying we should or shouldn't. I'm just saying we haven't answered that question, at least not to my satisfaction.

DR. CURRERI: One of them I think is to decrease this enormous range which just doesn't make any sense of paying indirect payments.

DR. NEWHOUSE: It would certainly have that effect.

MR. MacBAIN: So we're saying that there's a need to redistribute the way the funds are being allocated?

DR. CURRERI: And mostly because of what Joe even said, in the accounting practices that were used to set them up in 1984, which were very imaginative somehow.

DR. WILENSKY: The issues are, do we like the incentives in terms of how many people are being trained and where they're being trained in terms of the distribution of monies. But in terms of the basic rationale about why should there be a Medicare role, it's to the extent that there really are higher patient costs in some areas.

That's really a Medicare role. Anything else would say, if there's a government role, it's something else, it's not Medicare. I think what Joe is trying to do is to really say there is an area which is Medicare and not just Medicare because nobody else is doing it, which is what

you usually hear as the justification.

MR. MacBAIN: No, it's patient care cost. To go back to the trainee analogy. If you buy a hamburger in a hamburger restaurant from a trainee, somebody getting on-the-job training, their little badge says trainee, you still pay the same amount for the hamburger. If you're still getting a service, that individual is still providing a service. It just may be at a lower rate of pay because they're also getting training from the employer.

Another way to approach it would be for residents to bill for their services under Part B and say yes, they're providing clinical services and they should be able to bill for it.

DR. NEWHOUSE: I think we can discuss that, but that's different.

MR. MacBAIN: It's different, but it's the same point that they are providing medical care and it's appropriate for Medicare to compensate somebody, whoever ultimately bears the cost, either the hospital or the resident, for that service. But I'm just trying to figure out where we get when we've done that.

Have we made the system any better by reallocating these direct education costs?

DR. WILENSKY: That depends upon your take of how you distribute your money among the hospitals and what kind of incentives you put in place with regard to --

MR. MacBAIN: Even then, how will we know that we've made the system better? What is it that will go away, that we can point to now that is bad that will go away or that is good that will appear?

MR. LISK: I think there's one other thing to consider, too, is whether you think the IME, in terms of that aspect of it, is it for a characteristic of a facility really, characterizing a facility versus patient care costs versus when you have the residents, considering your residents really in there including those costs that we have excluded there.

But I do have, in terms of thinking about in terms of the other types of facilities, in terms of where training is going, there's a lot of implications that we'd have to think about because a lot of training is occurring out in other settings and then whether it's appropriate to be

including that time then of those residents, if they're not actually in the inpatient hospital setting as part of the IME in that case.

DR. CURRERI: Why not? If you're just taking it from DME and putting it into IME, then it's up to the hospital to distribute it appropriately.

DR. NEWHOUSE: The issue is, how is the hospital being paid for Medicare patients or how is somebody being paid for Medicare patients in those other settings.

MR. MacBAIN: Let me try this from a different angle. If we look at the IME side of it where it's easier for me to picture some difficulties with IMEs still being paid on the basis of admissions, it doesn't take into account the fact that hospitals incur patient care costs in the outpatient setting, nor does it take into account the fact that residents may exist elsewhere and those other settings may also have characteristically higher costs.

If we do that, start from that point, then -- I think I'm coming around to it -- to the view that if we solve IME to deal with those other issues, we haven't solved it completely unless we deal with the patient care costs

that we're now calling DME, direct education, and somehow fold that in. Is that fair? So this is the missing piece in coming up with a better IME allocation approach?

DR. NEWHOUSE: I think that's right.

MR. MacBAIN: I think all you're saying is this is really a component of the same larger universe of costs that we're trying to measure through the regression approach in IME?

DR. NEWHOUSE: Yes, yes.

MR. MacBAIN: So it should include it in that and then we can have more confidence that we're making the thing better when we reallocate IME.

DR. NEWHOUSE: And I think if I follow on my logic, I would include the outpatient costs in there, too.

MR. MacBAIN: The two things that I'm concerned about, I'm looking for problems in all of this, now that the numerical issue has been addressed in the Balanced Budget Act, I'm less concerned about that, but there still are issues about recognizing --

DR. CURRERI: You mean you're talking about the cap now?

MR. MacBAIN: Yes. There are issues of recognizing the implications of the shift from inpatient to outpatient care and also the implications of non-hospital settings as the principal setting for resident training. Those are things, I think, on the IME side that I can is a problem.

DR. NEWHOUSE: But remember, one of the implications of this way of looking at it is that now we may get down to what is causing the differences and whether we want to pay for them in patient care. As I say, as I read the debate, I personally think, although I don't think anyone can tell one way or the other, that the bulk of the costs, the extra costs that teaching hospitals are a different style of product. A different product, if you will.

DR. CURRERI: And a different case mix.

DR. NEWHOUSE: I think it's less the case mix, but people could differ. Since you can't measure it, I don't know how you'd ever settle it. And I think to the degree it's a different product, people have basically said we want to pay for it. If we're, quote, seriously ill, we really

want to go to the teaching hospital.

Now the question is, what's the analog to that on the outpatient side. To what degree is it a different product on the outpatient side? I don't know the answer to that question.

MR. MacBAIN: It probably is. If you use the simple example of more lab tests, you'd presumably find that same tendency in outpatient treatment as you do inpatient. If there's a different style of practice, you would think that --

DR. NEWHOUSE: But is it a question of -- is this something that I should want to pay for? See, to the degree that the resident is klutzy and he takes more time or she takes more time and orders more lab tests that aren't really useful, that's what I'm calling a training cost.

MR. MacBAIN: But you're still arguing to lump it all together in one packet.

DR. LAVE: I think that this is extraordinarily exciting, but I think that the way to do it is I'd like to give Joe and Craig and exercise and that is, if we're going to think in this way, and I think there are advantages to

doing this, would be to lay out what it would mean -- forgetting about how we currently do things, even though it would involve a big change so we can think about things, for instance, and we can think about things like if one does it this way, what does it mean for things that later, in fact, we may want to subsidize?

Now, let me sort of tell you where, in fact, I'm coming from. At one point in my career, I did a study on training in the outpatient sector and looked at family practice doctors. People were very concerned about the training of family practice doctors and how you get people to go into family practice, and whether or not, in fact, you would get people to go into family practice if you did not subsidize their training costs because they could, in fact, not generate enough revenue through their clinical care to do this.

I mean, you could sort of study the practice of what went on in these settings. So that it might be worthwhile, I think, to think through. If we're going to take this epiphany, which is really a major change in thinking about things, because there are lots of things that

happen once you do this, one of which is that I think it leads you to thinking about care as being integrated across the Part A and the Part B services.

You can't think of the physician in this way and the training without thinking about it, in fact, as being an integrated product. It seems to me that that then brings you, what happens in the inpatient setting and what happens in the outpatient setting and how, in fact, should one think about this.

Are there sort of different ways that it ought to be thought about? I don't know, when I did my work on the outpatient setting, what happens is that in the outpatient setting, the patient does not get a better product. It actually gets a worse product. I don't mean really worse, worse. You get a nice doctor, cute looking guy, but it takes longer and you have other things to do with your time.

You have to wait around more to have the resident come in, so when you are in an inpatient setting, you know, you could have all these people come in and it may relieve the boredom. When you're in an outpatient setting, you don't have the same issues.

So I think that rather than to sit here and think about what we do about the IME, what would we do about the DME, I think it would make more sense to say, suppose that this, in fact, we were going to take the view that the residents in fact were developing their own human capital and they ought to be bearing the cost of this.

What would this mean in terms of how we ought to think about the big picture?

DR. NEWHOUSE: I don't think we have to say ought.

DR. LAVE: Well, do.

DR. NEWHOUSE: Do. But the ought, I want to come to your family practice example because -- in my experience with outpatient is similar to yours on the training side in that the early stuff I did suggested that residents were much less productive on the outpatient side. They mostly stood around -- they much more stood around and watched. Whereas, on the inpatient side, they much more did.

DR. LAVE: But there also are issues where now we really don't --

DR. NEWHOUSE: But now if you want to go to family practice, that's really work force planning. There, I

think, now we really are talking about explicit training subsidies and that shouldn't be now general revenues.

DR. LAVE: I agree with you. But that's why I think if we think about this thing sort of in a way, particularly given now the way we want the practice to go, what would be the implications. I think it would be easier to do it if we sort of had played a game, which was, suppose that we could start from scratch and design this all over again for the Medicare program.

We may back into where we were, but then we would sort of get a sense for how you would think about the outpatient department in this context and how you would think about everything else, and then we could compare that with where we are as opposed to trying to take where we are now and get to where you want to go.

I think it would be better to sort of say, if we have a different model, what would happen, and then see how we would implement that and then come back and forth across it.

DR. WILENSKY: Let me ask if Woody and Spence can try and keep their comments brief. I think it would be

useful to go to Judy and have her start the IME discussion and then we can continue this, but if there's something you'd like to raise before we do that? I just say that because these discussions are merging together. It may be that we can make more sense of them.

DR. MYERS: My comment was going to be that we seem to have started this discussion sort of in the middle. I thought we were going to talk about whether or not there should be a role and that we would get into the issue of the assumptions in 1984, all of the perverse impacts that have occurred as a result of this that we created, and an inability to respond.

I thought we would get to the point that we would decide that there needed to be a long-term fix to this problem so that we wouldn't have to keep revisiting it each year and that we would ultimately come to the point where we would want to decide whether it should be decoupled in some way from Medicare or, because of all of the worry and concern that if it's decoupled, that it will be impacted negatively and hurt people, that we would couple it, but couple it in a different way.

But we seem to have sort of started with therapy instead of diagnosis here.

DR. LAVE: We took Joe's statement as the diagnosis.

DR. MYERS: Have we made the decision?

DR. WILENSKY: Well, I think that -- I don't know that we've made the decision. It's a different way of looking at direct medical education, not as a training cost, not as a subsidy for training, but as a part of the cost of patient care in teaching institutions, and that's just a different way to look at it.

Now, in the end, we may or may not wish to do that, but it does change the nature of the questions you then ask about direct medical education. So to the extent you think this is an appropriate or legitimate way to think about them, to put them together and to look at all of this as a change in the cost of providing health care to seniors in teaching hospitals, and that that's really what you're trying to account for, it does change how you look at it.

So in that world, this is now an appropriate discussion to go in. If you haven't bought into that, then

you may want to keep them separate.

DR. CURRERI: But I think in answer -- the key is what we haven't discussed yet and that is how you would redistribute the money that you move from one section to another.

DR. WILENSKY: You have to take that on anyway.

DR. CURRERI: We have to take that on one way or the other. That's the key thing you're asking.

DR. MYERS: And how in the future, when medical care changes even more, when all of the incentives that we've put in with whatever we do seem to have a different impact, how are we going to come back and readjust, and is this program the right place to put those kind of policy decisions. Are there any alternatives to consider and do we want to make any recommendations along those lines, or do we want to continue with the assumption that it should stay connected some way to Medicare and then try to fix it within that connection.

DR. WILENSKY: To the extent that you think that there really is an issue with regard to the cost of delivering care, then it is a Medicare cost and it's really,

to the extent that you are trying to subsidize something else, then you can have a debate about, well, maybe government, but not Medicare.

But this really changes how you look at it in a way that makes it much easier. Yes, this is actually Medicare costs, when you think about it, to the extent of its affecting the cost of treating patients in these settings or whatever settings Medicare patients go to.

DR. CURRERI: I think it's also, to most people who are involved in teaching DME, much more -- it represents much more stability in keeping it in the Medicare program because if it goes into general appropriations, there's a potential for political juggling of the funds every year, which scares a lot of people off.

DR. MYERS: I agree. But is there a way to keep it within Medicare, yet provide some opportunity to tinker with it, to fix it, to adjust it without having to require a congressional review, without having to --

DR. NEWHOUSE: I think the answer to that is no. There's no way to keep it in Medicare without having congressional review.

MR. JOHNSON: I think the answer to Woody's long term concern is just make my car run right now. Joe, on your epiphany, I just wanted to address the one issue quickly of uncoupling the training and the medical treatment, and I guess it goes back to the political dilemma. Are we going to find ourselves, if we do that sort of thing, putting training in general appropriations in something we call paying for care over here in the Medicare program that the Congress could decide to do something on the training side that would be totally different if it's uncoupled so that it would impact, I don't know, the supply of physicians, the types of physicians. Maybe they decide not to pay for any educational costs or whatnot.

I just think we need to look at that uncoupling in terms of potential political balancing, that's all.

DR. CURRERI: Joe's point is that it's the trainee is the one that's paying for it. He's paying the training. All he's advocating is that the payments be for patient care.

DR. NEWHOUSE: Or recognized as that's what the costs are.

MR. SHEA: Just a point that when we talked about this recently, we had some discussion about, well, what is Medicare getting for its dollar. Some of us were expressing the opinion then that Medicare ought to at least be getting some influence on the preparation of physicians for the Medicare population, particularly as you look forward, geriatric preparation and whatever, which argues against, I think, what you're saying.

DR. NEWHOUSE: Or says you'd have to do it some other way. You'd have to do that through the direct process probably. Maybe they could be melded together, but it doesn't go as well together, you're right about that.

MR. LISK: Actually, your comment, which I was going to make, is one of the things I think that you have to think carefully about is what the implications of doing something like this would be on the incentives related to the determination of how residents are trained in terms of location.

DR. NEWHOUSE: But if you -- we're paying roughly $7 billion in direct and indirect now, and if you think the $7 billion is basically a patient care cost, then that leads

you to, I think --

MR. LISK: But it's also, though, considering it across settings because of how training has moved to other settings in terms of the --

DR. NEWHOUSE: Considered what?

MR. LISK: It's across settings, though, in terms of when you're talking about those things.

DR. NEWHOUSE: Yes. Let's go on to Judy.

MS. XANTHOPOULOS: We've laid out questions for the indirect payment as well. We believe that the indirect payments are intended to address the higher costs of patient care, as Joe has said, and we've identified basically four characteristics, four features that contribute to the higher costs, unmeasured case mix differences, stand-by capacity, the introduction and testing of new technology, and inefficiencies in the teaching process.

In our work, we've been looking at the issues about what is the IME intended to address, and it's generally speaking the higher costs associated with the teaching that are associated with teaching hospitals and the fact that they provide a different mix of services.

One of the points that is, I guess, of concern in a lot of the literature is that -- or a lot of the different parties -- is that while the services are not exclusively found in teaching hospitals, there is a higher concentration of these types of services, whether it's stand-by capacity or new technology or whatever, but there is a higher concentration found in teaching hospitals.

There is a concern that if the money is not directed to teaching hospitals through the IME payments, that there would be an undersupply of these services throughout hospitals because they are costlier to maintain.

Now, the question about whether these problems are better or worse than when they started making the IME payment, one of the concerns for the hospitals is that price competition has made it much more difficult to provide a lot of these specialized services.

I think that one point to be made is that it has put a lot of importance on the IME payment or put a lot more pressure on the payments from Medicare because of the funds drying up from other sources. So there is a question about whether or not what would happen if this money is either

redistributed or is cut or reduced to the hospitals. There is a lot of pressures on the hospitals.

DR. CURRERI: Isn't it being reduced anyhow gradually now over three years down to 5 percent or something?

MR. LISK: Point 7 percent.

MS. XANTHOPOULOS: Gradually, yes. We have basically two questions, one technical and one normative. Is the IME still the right mechanism to pay teaching hospitals? We believe a big part of it comes into the unmeasured case mix differences that teaching hospitals do have. They do have a different case mix and they do have more severe cases. You see a lot of evidence of that.

And then also, the payment system does rely on the intern-to-resident bed ratio, which does create incentives for hospitals to increase the number of residents. So we want to ask from a technical point of view, is this the right way to make the payment, and then the normative question is, is Medicare the right vehicle, and I think we sort of skipped over some of these, whether or not it should be a direct appropriation or perhaps an all-payer system.

But those are the questions.

I think we'll stop with -- well, I'll go ahead. The things that we had talked about staff-wise in terms of improvements to the IME payment system would be to go with an update case mix index, to update that DRGs, to try and pick up a lot of the complications in comorbidities that we believe are observed, and then do some improvements on the econometrics and reestimate the equation.

I might add that the update to the case mix index work is something that probably would take a considerable amount of time, would not be ready for the August report. The other work, should we redo the regression analysis, would be something that we could do in time for -- maybe it won't be August, but that report, but the case mix work would be something that would take a lot more time.

DR. WILENSKY: But Judy, let me just ask, in an instance like that, if we thought there was an improvement to the calculation, we could presumably discuss --

MS. XANTHOPOULOS: How to go about doing that?

DR. WILENSKY: -- what we thought would be an improved way of measuring it and how to go about it and the

fact that we didn't have the number for 1999 wouldn't make much difference.

MS. XANTHOPOULOS: Right, but it's such that we could continue to work on, right. So we're back to the questions, I guess. They're basically the same questions.

DR. WILENSKY: But I think the issue, when we talk about, is the IME payment mechanism still appropriate and is Medicare the right vehicle is, what is it that we're trying to do here, to the extent that we have a cost reimbursement system and the costs to these institutions is different or in other institutions that provide training. It doesn't have to be the hospital.

Then that would argue, if you're having cost reimbursement, you ought to have an adjustment to the extent that there's a difference in costs. Again to my mind, really, it does argue that Medicare -- to answer that question, Medicare is the right vehicle.

DR. CURRERI: Could I ask a question to both Gail and Judy? In your second thing there, is Medicare the right vehicle, Medicare, as I think Gail just pointed out, is the right vehicle, but it's really only paying a part of the

indirect costs. So it doesn't exclude an all-payer system.

One thing I think Jerry was getting at is that everybody benefits from education, graduate medical education, in supply and they go out to both teaching and non-teaching hospitals, patient care settings. So I don't think they're exclusive, necessarily.

DR. CURRERI: I don't think they're exclusive necessarily because I think that we still need to consider potential for an all-payer contribution.

DR. WILENSKY: Although presumably, the person who benefits the most is the person being trained.

DR. CURRERI: You've already said he's paying for that training by taking a lower salary.

DR. KEMPER: I guess on this all-payer system, in a sense, the logic of what Joe is proposing is an all-payer system because it says it's part of patient care and presumably private insurers pay more because the cost of care is higher.

I think the big difference is that presumably, if I were a health plan -- you all can correct me, but what I would do is I would say, you have this routine procedure.

Are there any special risks? No. You go to the community hospital where I can negotiate a lower rate. Are there any special risks? Then you go to the academic medical center and we pay the higher rate? Is it a rare disease or whatever?

So the rest of the system will be moving toward differentiating patients as to who goes to the high-priced service; whereas Medicare fee-for-service wouldn't be. So I think that's the sense of where the all-payer kind of implicit assumption breaks down.

Whether that's a bad thing I don't know, but it would mean that Medicare would end up paying a disproportionate share of these higher stand-by costs.

DR. WILENSKY: The standby, but not the actual use cost.

DR. KEMPER: Whatever it is that is making the patient care higher because there are more residents there, Medicare will pay a higher share of it because it won't sort out patients, only the patients that need that extra care.

DR. WILENSKY: Wait a minute. I don't agree with that. Medicare will pay a higher share because it will

presumably have more of its patients actually going there.

DR. KEMPER: Exactly, exactly.

DR. LONG: Whether they need to or not.

DR. KEMPER: That's the point

DR. WILENSKY: But it's not that other people -- it's that they're not using it.

DR. KEMPER: Well, I guess what I'm saying is --

DR. WILENSKY: If they were using it more, they would be paying it more.

DR. KEMPER: But if part of what Medicare ought to be doing on the fee-for-service side is becoming a smarter payer, this particular piece isn't --

DR. WILENSKY: Well, that's a whole other issue. That's a much broader issue.

DR. KEMPER: I understand that, but the implication is, as a practical matter, that Medicare will end up paying a higher share of these additional costs, which may not be a bad thing.

DR. NEWHOUSE: Higher relative to what?

DR. WILENSKY: Not higher relative to now.

DR. KEMPER: Not relative to now, but relative to

what the trend will be as more --

DR. WILENSKY: But again, they would pay -- if we assume that Medicare, for political reasons, chooses not to be a direct purchaser and that the private sector does choose to be a direct purchaser, then Medicare will pay more of this cost because more Medicare beneficiaries will choose to go there.

But what you're really saying is, they will be paid in proportion to who uses them. Well, that's hardly a bad thing.

DR. KEMPER: That's exactly -- and one of the implications, as you just said what the implications are. That's my point.

The second thing is, I think if we go this approach, the facility -- I think there's a question of how much of this payment ought to be estimated on a facility-specific basis as opposed to some sort of class average basis, because it seems to me that the actual cost of a facility will depend on a lot of different historical things and maybe efficiency and so on, number one.

And number two, that the distribution of costs

will be much greater if we take facility-specific costs into account. So I would urge consideration of running the regressions and doing the facility-specific costs, but then thinking about ways of aggregating it into classes or something like that so that it isn't entirely facility-based.

DR. NEWHOUSE: I thought about that, Peter. My problem with that is, all the rest of PPS isn't that way. We have wage adjusters and so on, but we didn't do hospital -- when we had PPS, we had in the transition, we had five years of facility-specific, of a blend, and then we were onto a national rate.

DR. KEMPER: Right.

DR. NEWHOUSE: The facility-specific that's on here seems to be kind of minor in comparison to what the original facility-specific stuff was that we decided not to recognize.

DR. KEMPER: Right.

DR. NEWHOUSE: That's not to say we shouldn't recognize this. It's just to say it's kind of inconsistent with what we've done elsewhere.

DR. WILENSKY: No, he's agreeing. He's saying --

DR. KEMPER: I'm agreeing.

DR. NEWHOUSE: Oh, you're agreeing? I thought he was saying we should do facility-specific.

DR. WILENSKY: No, no.

DR. KEMPER: No, no.

DR. NEWHOUSE: We're agreed.

DR. KEMPER: Well, except that I thought --

DR. NEWHOUSE: Transition is another issue.

DR. KEMPER: And reestimating the regression or whatever has more variation.

The third thing I wanted to say was, you said, well, the actual basis of payment, we'll figure that out. But I think that's really very critical.

DR. NEWHOUSE: Absolutely. That's the reliance on IRB point as long as we haven't seen any other contenders that would --

DR. KEMPER: But I think this incentive to train additional physicians is a really major issue.

DR. LAVE: That's been squashed.

DR. WILENSKY: If we were to take this mindset on

it as a way to look at the problem, then it would suggest that is really now the big focus, is we're uneasy about the IRB. What are the set of options? That is the big thing.

MR. LISK: One thing I wanted to bring up to remember, too, is in terms of one of the other things of the IRB. The IRB assumes that these other things maybe that you're paying for with it related to those patient care services are going on in all those facilities related to that actual count.

There are things like different stand-by capacities of some hospitals that might have that increase their costs that they're paying based on the IRB, and in another facility, it doesn't have those type of stand-by services. They have the residents you're paying for, for doing that, even though they're not doing it. There's the implication of you don't have any, I guess, accountability in terms of continuing for those services --

DR. WILENSKY: But that is part of having an average in the costs.

DR. NEWHOUSE: Yes. Some hospitals have more nurses.

DR. WILENSKY: To the extent that you're trying to move away from facility specific, but class cost, I mean, it wouldn't be inconsistent to say, you're paying for what is, on average, within a type of a facility. You're really not trying to mimic facility specific cost. That isn't the world we're in.

MR. LISK: But classes though too, you have to consider the steps that you may get in putting classes in in terms of those incentives that you correct to.

DR. WILENSKY: Right.

DR. LAVE: I really want to caution. I think that with all of the problems with the IRB, that the nature of those problems are an awful lot less than they would have been under a class-based system where the differences between one class and another would have been horrendous. All you have to do --

DR. NEWHOUSE: But you didn't have a good way of defining classes.

DR. LAVE: I don't know whether we have a better way of doing it now, but there are real problems with developing systems that have strict boundaries, because you

spend all of your time trying to have people argue to get -- to cross the boundary, and I think we've had a lot of experiences with that.

I kind of wanted to make a couple of comments on this. I think that Medicare -- I would say Medicare is the appropriate vehicle for paying for higher patient care related costs that are associated with things that we can't measure but are good and true, like the unmeasured case mix differences. And we probably are not going to be able to measure them. I would point out, for instance, that there were a whole series of studies that were done on severity and it turned out that on what they could measure on severity, they could not find any differences, if I remember that literature correctly.

DR. NEWHOUSE: That's why the bulk of it is with product changes.

DR. LAVE: So you have a product change, and then you also have some very subtle kinds of product differences which you don't pick up, like a very expensive brain meningioma as opposed to a minor one, which doesn't come up on patient class. So there are various differences which

are so subtle and make a big difference, but you're never going to find a measuring system that's going to pick them up in any way.

The severity system, we did Medis Group's, we did Susan Horn's, we did staging and it turned out that in those variables they really did not find any differences, which is not to say there aren't differences, it's just that it's going to be very difficult to find them.

MR. PETTENGILL: That's true that's what happened, but remember that's pretty old.

DR. LAVE: Right, that's true.

MR. PETTENGILL: Those things are more than a decade old.

DR. LAVE: But do we have better measures now?

MR. PETTENGILL: In fact, I was the project officer at HCFA on those studies, so that makes it really old.

I think, actually it's true, we cannot capture all of them. There's a fair amount of variance that you're not going to be able to get. But by the same token, you can do a lot better than we're currently doing with the present set

of federal DRGs. The APR-DRGs will do a substantially better job.

HCFA had a refinement that they were working on at one time that I think would have made a substantial difference. But they had considerable fears about implementing it because it treated the comorbidities and complications differently than the current system does and it would have created the opportunity for upcoding.

ProPAC had a recommendation about how to deal with that, allowing them make a projection in advance and then correct for errors after the fact once you could measure of the changes. And you could go through that exercise and get some of what is now in the IME out and back into the DRGs where it belongs.

There were also modifications of the weights in a number of other things that might have helped.

DR. LAVE: Would have made a big difference?

MR. PETTENGILL: So I wouldn't rule that out as unlikely to be successful, but it's not going to solve the whole problem by any means, because there's a lot more in the IME, the adoption of the new technologies where you're

doubling up on services, you're doing the MRI, you're doing the old x-ray technologies, too.

DR. CURRERI: Or you're buying the first MRI and then two years later the price is way down.

MR. PETTENGILL: That's right, you're always at the leading edge, and the costs to the hospital are higher. You're duplicating services in order to test the new technique. It's doing new procedures with --

DR. WILENSKY: But it is all patient care.

MR. PETTENGILL: Sure, it's all patient care, but it's not case mix. So that's the part that you're not going to catch. That's not the only part you're not going to catch, because you've got these cases -- when you get up into the high cost categories, you've got enormous variance there, which really I think is --

DR. NEWHOUSE: By high cost, you mean the high weighted DRGs?

MR. PETTENGILL: Yes. You've got enormous variance there which I think reflects differences among patients and how long they live, how long they're in the intensive care unit and that sort of thing.

DR. CURRERI: And I think it's hard sometimes to catch the standby capacity difference. I mean, the presence of burn units, and 24-hour emergency rooms, and surgeons in the hospital 24 hours a day, and so forth.

DR. LAVE: What I was going to wonder about was as we were thinking about this in terms of Medicare's role as a payer and the government's role in supporting these institutions, was that clearly for those things that Medicare -- that directly affects the patient, that is Medicare's role. But what I was wondering about was whether or not there was a more sophisticated way to think about some of the standby capacity issues that would turn more towards a global payment system as opposed to some of the individual payments.

DR. WILENSKY: But would it be hard -- I mean, if you thought that, I'm not sure why you'd think it would be the federal government.

DR. LAVE: No, I'm not necessarily saying, but more of an all-payer kind of a system for -- the question was, should everything be related to Medicare that picks up? And for some things, it's hard to sort of believe that

direct -- whether you liked any of those other things would depend upon the dimension of the factor that was pushing the higher price is what I was thinking.

DR. WILENSKY: Let me say why I think -- I don't see the all-payer as making any sense on this. To the extent we think that part of it is the use and Medicare ought to pick up use for the seniors, that's fine. To the extent we think there is a public good aspect and you want to have a contribution, it would seem to me much better to argue for general funds --

DR. LAVE: I agree.

DR. WILENSKY: -- government, than to try to have some kind of parceling out of other payers who are already making directed use in terms of where they're funneling patients, if that's what's going on. And to the extent that they actually use the service, then they'll pay because the cost will be higher.

MS. XANTHOPOULOS: But a lot of the services sit there and are not used until something comes up. So if it is, this is the only thing is a caveat --

DR. WILENSKY: But this is government.

MS. XANTHOPOULOS: -- yes, if it is government then it would have to be a consistent source of revenue so that those services can exist for the chance that they're needed.

DR. WILENSKY: But of course, then you get into the question of, if you're going to have government pay for it, do you want to have government decide whether it wants burn units --

MS. XANTHOPOULOS: Right, at all.

DR. WILENSKY: -- everywhere, or standby capacity everywhere they happen to be. So this issue, if it's the patient care, that's pretty easy. If you're going to ask government to pay for some of the standby capacity, then I think you ought to assume that government ought to have some say about whether or not the location and the amount of these other things are worth paying for by government. But it ought to be government that --

MS. XANTHOPOULOS: One of the things about the teaching hospitals is that the features are, they're associated with, or they're commonly found -- they're not exclusively in teaching hospitals, but there's a high

correlation between those services being clustered and found in teaching hospitals as opposed to being generally distributed. And even now the distribution is probably not optimal, but there's clearly -- their presence is highly correlated with being a teaching institution.

DR. WILENSKY: I know, but that still doesn't change the question of --

MS. XANTHOPOULOS: But I mean, it's just hard to separate. They're not clearly separable in terms of payment. I mean, it's difficult to separate those features from the higher cost of that institution as well. I mean, I would think it would be harder to parse those --

DR. WILENSKY: But again, there are two different kinds of cost. One is the higher patient cost of the Medicare patient. To the extent you want to have a public contribution to the other higher cost, then you ought to ask whether or not there ought to be some public decisionmaking about the availability and distribution of those services for which we're asking for public contribution.

DR. CURRERI: But the market can do some of this. I'll give you an example.

DR. WILENSKY: The market can do a lot of it. Just don't have the market be doing it if the public is contributing.

DR. CURRERI: I'll give you an example of, for instance, taking burn units. We had 140 burn units as little as five years ago, and when it became terribly inefficient, mainly because DRGs paid very little -- when burn units became inefficient, they just disappeared. The two-bed burn units and the four-bed burn units disappeared and now we essentially have a system of regional burn units that may cover one or two states, purely driven by the market. The hospitals simply could not afford to keep the burn unit unless you had at least 100 admissions a year in order to keep the rehabilitation staff, and social workers, and so forth.

The market did that even though the government was paying most of the money. The government really didn't have to do anything because you just couldn't survey if you didn't have 100 admissions minimum. In most cases, the ones that are doing really well have 400 admissions.

MR. LISK: There are a couple of pieces of

information I think that might be useful just for you to know about. One is, Lewin has been doing some work for Commonwealth Fund looking at the effect on hospital costs of the standby capacity type of services, and research and those types of things, and it's shown, including indirect coefficient, has seen a substantial reduction in the indirect coefficient.

They didn't have in their analysis these other type of case mix adjustments that we're talking about, but their work is proceeding and will hopefully be done before the next Commission meeting. It may be something that may add to some of your discussion.

The other thing about the point that you just mentioned about burn units, David Blumenthal and Joel Weissman had done -- and I don't think this research is published yet, but they had done some case study work out in California and looking at some other markets about certain types of activities in terms of standby services in some of those areas.

They found, actually in some markets where you've gotten only one provider of those things, where you don't

have the competition, they've been actually, for burn care, actually start making a profit on something like burn care or trauma care when they can actually charge what is the real price to the provider of those things. But a lot of those types of services are cross-subsidized from other types of funding.

DR. CURRERI: But my understanding is that most of those that have begun a profit is because they've been able to reduce costs because of volume.

MR. LISK: That's another aspect of what may be happening, too.

DR. CURRERI: In other words, if you have one full-time PT, and one full-time OT, and one full-time dietician and so forth, you've got to have 40 beds. Otherwise you can't pay for them. And they can't operate efficiently unless they're doing it full-time.

DR. LAVE: So it's not standby, it's filled.

DR. KEMPER: That's right.

MR. LISK: It's making less standby.

DR. LONG: You may have spoken to this and the Lewin study may speak to this. One certainly could imagine

facilities with this standby capacity with the efficient burn units, the hospital buying the first generation of equipment, maybe even having some kind of research grants, et cetera, with no residents at all.

I don't know if such a hospital exists, but is true tertiary synonymous with teaching, or do we have some examples of where these things have been unbundled, because that could certainly get us down the road toward thinking about some of the things we've been calling indirect medical education that may not have anything whatsoever to do with medical education, but simply are dealing with these unmeasured case differences.

DR. NEWHOUSE: I think that's how we got into IRB, because that was the best thing we found that tracked these costs. Julian ran his regression when he and I both had less gray hair, and it came up with this big relationship.

MS. XANTHOPOULOS: One of the things of using the DRG refinements is that it would affect all. It would not be just a change to teaching hospitals alone, it would be all hospitals. So that to the extent that they had those services and had more complicated or severe illnesses in

their cases, they would get more or less according to what they had. So it would not be something that's limited, in terms of the payment system, if you do the DRG refinements.

MR. LISK: And even historically related also to the DRGs too is how the DRG weights are calculated based on charge weights versus cost-based weights too. Those things that have been subsidized through other things in the facilities are undervalued for Medicare relative to those things. So those type of improvements would also make improvements and potentially reduce what contribution the IRB would have in measuring unmeasured costs in the hospital.

DR. KEMPER: Joe, if you could clarify a basic thing in light of this discussion of the standby cost. What costs actually go into the dependent variable?

DR. NEWHOUSE: You mean, under the current system?

DR. KEMPER: No, under your proposal. The burn unit costs go in?

DR. NEWHOUSE: Yes.

DR. KEMPER: They're all in there?

DR. NEWHOUSE: Yes. I mean, the cost of taking

your board to Tahiti don't go in there.

[Laughter.]

DR. LAVE: The audited costs.

DR. WILENSKY: Any more comments?

I think we clearly have got to give some more thought to -- this really focuses the attention and the importance on the distribution issue. But maybe people can think about all this over -- we can continue the discussion this evening if people could stand any more of it. We've had a very long and full day.

But I think it's important for people to think about this as whether it helps your conceptual view of what the problem we're trying to solve, and where we would turn for what pieces. My sense is this really has helped me in terms of my thinking about this issue.

DR. CURRERI: The problem is going to be able to do appropriate simulations and so forth before June 1st or July 1st or whenever we have to do it.

DR. WILENSKY: I also think that to the extent that we have some indication of the direction that we're heading and the kinds of things that we need to do is a

better rationale. If we attempt to get another month or two for our report, it would be because we have a certain set of activities that we would now like to pursue which has more consensus on its direction than at least we've heard to date. I mean, I think that makes it at least a more appealing request.

So this is an issue -- and I'm not asking people to sign off on now, but I think it's something that would be useful to give some thought, see if you feel comfortable about this, and we can talk about the next steps.

Public comment?

DR. CURRERI: Just before that, could we kind of get the staff at the next meeting in April to try to sort of conceptualize this whole thing for us and put it down in writing?

DR. ROSS: Yes.

DR. WILENSKY: Go ahead.

MS. HELLER: Karen Heller, from the Greater New York Hospital Association. Back to the conversation about direct GME. Dr. Newhouse, I think that you're conception of these costs as patient care feels very right to me.

However, I don't automatically go to including them in the PPS because they really are not comparable, for the reasons that Julian cited in terms of the historical differences in financing. They feel more like exempt psychiatric services, or organ acquisition costs that were left out of the PPS, not because they weren't patient care but because they really weren't comparable. So I just wanted to share that thought with you.

DR. WILENSKY: Any other comments?

Commissioners, we meet at 8:30 tomorrow morning.

[Whereupon, at 6:15 p.m., the meeting adjourned, to reconvene at 8:30 a.m., Friday, March 19, 1999.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites Hotel
1250 22nd Street, N.W.
Washington, D.C.

Friday, March 19, 1999

8:42 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
P. WILLIAM CURRERI, M.D.
SPENCER JOHNSON
PETER KEMPER, Ph.D.
JUDITH R. LAVE, Ph.D.
D. TED LEWERS, M.D.
HUGH W. LONG, Ph.D.
WILLIAM A. MacBAIN
WOODROW A. MYERS, JR., M.D.
JANET G. NEWPORT
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
GERALD M. SHEA

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P R O C E E D I N G S

DR. WILENSKY: We had a very full, successful day yesterday. We have all of today's sessions and the one we didn't get to from Beth yesterday, so I think it's important we get ourselves going.

Nancy, improving quality of care for beneficiaries with end stage renal disease?

MS. RAY: Good morning. We're going to talk about this morning quality of care, the current state of quality of care among end stage renal disease beneficiaries, and possible recommendations for the Commission to consider.

The Social Security of 1972 created an entitlement for Medicare for all persons with a diagnosis of permanent kidney failure who were eligible or insured for benefits under Social Security, their spouses, and their children. In the 26 years since its establishment, the program has been quite successful, saving many people from premature death.

It's important to note, and I always try to get this in whenever I can, that 93 percent of all patients with permanent kidney failure are Medicare eligible. There's

approximately 7 percent of patients who are not, and they are covered under a mix of programs including Medicaid and the Department of Veterans Affairs.

Since the beginning of the program, the patient population has grown about 25-fold, from 10,000 in 1973 to nearly 290,000 in 1996. This increase is in part due to the increased clinical experience and improvements in technology and techniques enabling the care of patients with complex and severe comorbid conditions.

For example, persons with diabetes make up 40 percent of all new patients and about one-third of all patients. Persons over 65 make up about one-third of all new patients, and half of all patients.

Numerous researchers have investigated and have tried to identify the effect of Medicare's payment policies on practice patterns and quality of care. As we're all aware, the composite rate has not changed for many, many years. As a result, researchers, including the Institute of Medicine, have reported that this has caused a change in practice patterns.

For example, the replacement of registered nurses

for technicians. Other organizations and researchers have also noted about the lack of diffusion of certain technologies because of the structure of the composite rate, like home hemodialysis.

In today's presentation we're going to look at quality of care among Medicare beneficiaries as measured by five quality indicators, adequate of dialysis, anemia, and nutrition, which is measured using biochemical markers, rates of hospital admission, and rates of mortality. For each of these -- for the first three we have proposed recommendations for the Commission to consider as well as possible research that you may want to consider. For the last two indicators we have proposed additional research in those two topic areas.

In addition to looking at quality of care, we're also going to briefly talk about several quality assurance projects that are currently being conducted, both by HCFA as well as by the National Kidney Foundation.

First measure I'd like to talk about is adequacy of dialysis. Inadequate dialysis dose shortens survival and leads to anemia, decreases the effectiveness of

erythropoietin, epo, malnutrition, and functional impairment. One-third of all in-center hemodialysis patients were underdialyzed in 1996. It's important to note here that nearly 85 percent of all dialysis patients receive in-center hemodialysis, and this typically is given three sessions, three times per week.

The composite rate does not differentiate based on the complexity and the needs of the patient. It assumes the dialysis patients are homogeneous for payment purposes. There's one composite rate.

What we are proposing that you consider is that a multi-tiered composite rate be created. This would allow for -- let me start again. A multi-tiered composite rate would take into account the clinical status of the patient, the time needed for dialysis. So if patients need longer dialysis sessions, if providers feel that they should be dialyzing more than three times a week, a multi-tiered structure could permit such treatment.

A multi-tiered composite rate, I believe, assumes that we have a heterogeneous population, which we do. We have many people who are older, we have many people with

serious and systemic diseases and they all need different types of treatment.

DR. CURRERI: Nancy, could I ask you, how did you define under-dialysis, or how is it defined for purposes of 30 percent?

MS. RAY: The urea reduction ratio. That's reported by HCFA in their core indicator project.

DR. LEWERS: Or the KV over T.

MS. RAY: Yes, but in HCFA's core indicator project they report the URR.

DR. WILENSKY: Nancy, do you want to go through and present all the recommendations and then have us come back and discuss each one, or would you prefer us to discuss them as you --

MS. RAY: I have no preference. We can discuss them one by one or --

DR. WILENSKY: Would you rather get a sense of the whole and then go back and take these -- only because it's not a really long chapter. Why don't you go through and do all of them and then come back?

MS. RAY: Okay. Anemia. Nearly 30 percent of

dialysis patients were anemic in 1996, and this information is again obtained from the HCFA core indicators with patients with a hematocrit of less than 30. Recombinant erythropoietin is the mainstay of anemia therapy.

Since 1989, it has diffused dramatically among ESRD beneficiaries. It really has revolutionized, I believe, the care of anemia among ESRD patients.

The two most recent changes or considerations to epo reimbursement that I'd like to discuss is, the first being in 1998 HCFA changed the epo reimbursement, the threshold hematocrit level. They increased it from 36.5 to 37.5. What that means is, based on the National Kidney Foundation DOQI guidelines, providers try to keep patients within a hematocrit range of 33 to 36. But this is very variable. It's not precise. It's not like you can specifically get a person to stay at a specific hematocrit level and keep them there.

Because of the variability, HCFA raised this threshold hematocrit level from 36.5 to 37.5, and the question that still remains is whether or not this level of 37.5 is high enough to permit providers the flexibility

that they need in managing ESRD-related anemia.

The second issue is, both OIG and HCFA, based on an OIG report, are recommending a $1 decrease in epo payment from $10 per 1,000 units to $9. This is based on the OIG report where they surveyed about 105 dialysis facilities and found, I believe, approximately 95 of them were paying less than $9 per 1,000 units.

Anecdotally, many people in the renal community are concerned that a reduction in the epo payment rate may differentiate -- may affect smaller dialysis facilities as well as those in rural areas. So the Commission can choose to either agree with the OIG-HCFA recommendation or not agree with it.

Malnutrition is another very, very important problem among ESRD patients, and approximately one-third of dialysis patients have clinically recognizable malnutrition based on their serum albumen levels. Available interventions include oral supplements, enteral tube feeding, intradialytic parenteral nutrition, and intermittent parenteral nutrition, otherwise known as IDPN and IPN, that is administered during the dialysis session,

and total parenteral nutrition.

Oral supplements right now are not a Medicare covered benefit. The IDPN and IPN is covered the same way as total parenteral nutrition is. It's a DME benefit. As a result of that, it's very difficult for many ESRD patients to obtain that therapy.

DR. CURRERI: Could I ask you, about one-third of the patients are underdialyzed, one-third of the patients are anemic, and one-third of the patients are malnourished. Are they the same patients?

MS. RAY: I don't know.

DR. CURRERI: I think it's important, because correction of one may fix the other two.

MS. RAY: And I think that's a very good point because it's very clear that patients who are underdialyzed, the effectiveness of erythropoietin is not as effective in those group of patients. There have been studies that have been published.

DR. WILENSKY: Could you do that analysis, to find out whether they're the same patients or not?

MS. RAY: No. I don't have the serum albumen data

in the HCFA database. I have the hematocrit data.

DR. WILENSKY: But you could do some overlap analysis.

MS. RAY: I could do some of that, yes, that's correct.

DR. ROWE: The concept here is that if you have a loss of renal function, renal mass, kidney mass, you lose the capacity to produce this hormone, erythropoietin, which stimulates the bone marrow.

In addition, the more renal failure you have, there are toxic effects of that that suppress the bone marrow. So that if you had two patients who had no kidneys, they had their kidneys removed, and one of them was frequently dialyzed, they would have less of that suppressive effect of these accumulated toxins on the bone marrow and they would be responding better to the epo than the other one who had no kidneys either but had more of these toxins.

So there are two effects here. One is the lack of the hormone. The other is the suppressive effect of the degree of toxins in the blood.

DR. CURRERI: But I really think the point is that if it's the same patients that have all three of these complications that we talked about, fixing one of them may fix the other two, without having to have supplementary programs.

DR. ROWE: Right.

DR. CURRERI: Just like the point you made that you are going to probably have to supply erythropoietin, obviously, because you can't supply it otherwise. But I'm not sure that many of these malnutritions aren't simply leaking of proteins when you dialyze the patient.

DR. ROWE: There's probably not too much.

DR. LEWERS: Peritoneally, but not --

DR. ROWE: Yes, and the other problem with the peritoneals is they constantly, are frequently infected and that has an important impact on their capacity to effectively utilize the nutrients, I think.

DR. LEWERS: I think if you were able to do that you would find that those who are underdialyzed are probably the ones who do not have -- are malnourished. I don't think -- and you may find some relationship with their anemia.

But epo does not work in the face of inflammation, it doesn't work in the face of several other factors. So you would find other patients who are well dialyzed who have an intercurrent problem, comorbid conditions which could and would produce the anemia.

So I think the two certainly would be a test. Because if you're underdialyzed you're not going to eat. And you try to get these people nutritional therapy, and you try to give it the way you can, and there are all sorts of programs now where they get the supplementals orally, but they're not paid for. So they can't eat them, and the dialysis facilities are trying to get samples. They're trying to do this in order to feed these people.

So some of those people are just simply -- they just do not have the adequate means to handle it. And we do use the IDPN and TPN.

DR. CURRERI: But would the answer be to dialyze them more frequently, or is the answer to not dialyze them as much and try to force external --

DR. LEWERS: No, I don't think there's any question -- you know, 25 years ago I was dialyzing people

who were not doing well. I was dialyzing them every day. And you know they do better. If you have a patient who's in the hospital having surgery, you dialyze that patient every day they do better, they get out of the hospital quicker.

Now if you do that, you've got to eat it because you're not going to get paid for it. But that's what's best for the patient.

I think that somewhere in our discussion today we need to talk about daily dialysis. I think there should be more added -- you do mention it, Nancy, but I think it should be added here because there are a number of papers now coming out. You probably have been contacted by one center that's doing a lot of this.

MS. RAY: Yes.

DR. LEWERS: But we can talk about that I think at another point.

DR. MYERS: Ted, we know that 30 percent of the patients are underdialyzed. But do we know that the reason for underdialysis is related to the rate, or are there other patient or physician or facility factors that fall into that 30 percent?

DR. LEWERS: There are a number of factors that are related to that. For instance, the vascular access and how good is your vascular access, can you get the flows needed. The compliance of the patient. Many patients just can't sit still for an extended period of time and will sign off. I mean, you've got a four-hour dialysis, four and-a-half dialysis, at two and-a-half, three hours they just say, get me out of here. If you don't take them out, they pull the lines out and walk out.

So there are a lot of other factors that are involved in that, and I've not taken a look at the 30 percent she's talking about because I know that in my facilities, I didn't have a 30 percent underdialysis rate. But the problems I had were the people sitting still that long.

DR. MYERS: It would be very interesting to know whether that 30 percent is concentrated either geographically or by facility. Because 70 percent are dialyzed well

DR. LEWERS: Right. I don't think it's geographic, but I don't have that data.

DR. LAVE: Could I ask a question? Does HCFA only pay for three dialysis sessions a week?

DR. LEWERS: Yes.

MS. RAY: Yes. You have to submit medical justification.

DR. ROWE: And a rate that has not been increased in 13 years.

DR. LAVE: I know that but --

DR. ROWE: Despite our recommendations.

DR. LEWERS: If there are some intercurrent problems that require, and you can justify it, they will pay for more. But it's a retrospective. I mean, I can't say, I think you need an extra dialysis today, Judy, and give it to you and know that I'm going to be compensated for it. I've got to do it retrospectively.

DR. KEMPER: Ted, is there a distribution of how frequently people have to be dialyzed?

DR. LEWERS: The dialysis formula depends on a number of factors. It depends on the size of the person. A very large, muscular male may well require much more dialysis than a small, elderly, frail female. Their dietary

consumption. I mean, if they're out there eating everything under the sun, yes, they're going to require a higher dose. So you have to calculate that dose, and you've got to calculate it, again on blood flows, what you can get out of your vascular access, a whole host of factors that you take into consideration. So it does vary.

Some people are very well dialyzed at three hours three times a week. But they're usually very small individuals who stay very carefully with their diet.

DR. WILENSKY: Why don't we continue on? There's more in the presentation, and we'll come back and then go through each of these.

MS. RAY: What I've included in your mailing materials then is a possible recommendation for coverage of nutritional therapies, IDPN and IPN under the renal benefit provision as opposed to the prosthetic device benefit provision.

In addition to that, interestingly, there is very little known regarding the efficacy of these interventions among dialysis patients who are malnourished. There hasn't been, to my knowledge, any case control, double-blinded,

randomized trial evaluating the efficacy. Consequently, I've put a proposed recommendation for you to consider that such a trial should be initiated to evaluate the efficacy of these interventions.

The fourth quality indicator that I'd like to discuss is inpatient hospitalization. Rates of hospital admission have remained pretty stable the last several years. It's important to note that nearly 40 percent of ESRD expenditures were devoted to inpatient care.

A study that used 1991 data looked at the risk of ESRD patients being hospitalized as well as what were the most frequent reasons apart from chronic renal failure. And I don't think that these are unexpected -- vascular access problems were second most frequent reason for hospitalization, followed by congestive heart failure, diabetes, and pneumonia, and influenza.

The proposed recommendation in your mailing materials is for additional research in this area to continue monitoring the reasons that dialysis patients are being hospitalized, as well as the risk of hospitalization compared to patients with other chronic and serious

disorders.

DR. LEWERS: Before you leave that one, take a look at the list for diagnoses and take a look at chronic renal failure. I hope that end stage renal disease -- and obviously a coding. But just the issues that are related, your chronic renal failure, your electrolyte disorders, your pulmonary edema, and congestive heart failure, these are all very frequent and frequently related to either an underdialysis or a weekend binge with a water bottle. These people are excellent at finding excess fluids.

So a lot of it is compliance. And it's an area too that has been a concern of the renal community is how do we deal with compliance? You've got to put yourself in this patient's position. Here's an individual who is hooked to a machine three times a week, probably needs more, who can't go out and eat what you and I eat, who has to be very careful, takes tons of pills, can't drink water. It's a depressing situation.

And yet, as you dialyze them more, they feel better, they obviously have a better feeling of themselves, but they do frequently fall off the wagon. And compliance

is a major problem. There are a lot of studies trying to figure out how do we comply, because almost half of those situations sitting up there were a compliance issue for the most part. Now certainly you get your heart disease and pulmonary edema, et cetera, on that basis, and infections are commonplace.

But you've just got to remember -- and we've not mentioned compliance. There's a lot going on in compliance -- you know, how do we handle this? But that list is a very important list for you to keep in your mind.

DR. MYERS: What is the difference between the centers with the best compliance and those with the worst? What are the characteristics that --

DR. ROWE: Patient population.

DR. LEWERS: A lot of it is patient population. A lot of it is the commitment on the part of --

DR. ROWE: The Seventh Day Adventist Dialysis Center has a different compliance rate than, you know --

DR. WILENSKY: Actually, I think this is one of the areas that I was a little uneasy about. Undoubtedly, it's true that patient characteristics are an important

factor. But as we have noticed in some of our other quality sections, the whole area about how we try to reduce medical error and improve systems, my guess is that we would see, in addition to differing patient characteristics, different levels of compliance and different levels of complications across different centers.

And one of the areas that I'd like to see strengthened -- and we can talk about this more in the discussion -- is the same focus on improvement in systems and reduction in medical errors in this area, because that's one area that didn't seem to be really hit very much.

DR. ROWE: I think that's an excellent point, Gail, and I'd also say that I think that if you were looking at the diagnoses that would be on this list that were associated with diatrogenic complications you would see, which you don't, hyperkalemia --

DR. CURRERI: Electrolyte disorder.

DR. ROWE: You might see infection, much more common because of the way things are handled at the access, hypotension during dialysis, and a seizure induced in which then the patient gets admitted to the hospital. These are

the kinds of -- hemorrhage, line opening up, shock. Those are the kinds of things that are related to complications, and it just turns out they are not on the top 10 list.

One of the problems, of course, we have in this discussion is that we don't want to blame the victim. The patient characteristics are the patient characteristics, and this is an extraordinarily difficult kind of regimen to maintain over very long periods of time.

I would think that the major patient characteristics -- and Ted has much more experience than I -- would be age. I think the younger individual, who is active, who is working, who has a family, who's going to dinners, who's traveling, who's doing all these things, has more difficulty in compliance than the 80-year-old woman who is sitting in one place all the time, more or less, with a lot of support services. I mean, those are the kinds of patient characteristics that I think determine it.

DR. LEWERS: Let me answer Woody. There's just two simple things in my mind. As in any patient, it's the patient-physician relationship that has the major -- but what I have found in this group is that you take a model

patient on each shift and that model patient dealing with another patient that is non-compliant, makes a big difference. So I try to get on each shift sort of a model patient that I say, hey, Joe, I want you to go talk to Mary over here. I've found that to be probably the most helpful.

DR. CURRERI: But if you've found successful methods to get patients to comply, could reimbursement be a form, can multi-tiered reimbursement be a form of incentive to have better compliance from center to center, if there are methods that can be introduced?

DR. LEWERS: We can talk about multi-tiered. I'm not as optimistic as Nancy is in that. I think that's going to be exceedingly difficult. I think it's interesting to try. I don't know anywhere where it has been tried. But I'm not sure of that.

MR. MacBAIN: Without getting into the specifics of how we were to change the payment method, if there simply were either a higher composite rate or broader latitude in terms of frequency of dialysis, is it likely that a change in the payment rate would affect the relative rate of hospitalization? It sounds like maybe, but not as much as

we might hope, because the compliance issues aren't going to go away.

DR. LEWERS: I think that, and I will predict for you that in the upcoming years more dialysis is what we're going to end up needing.

DR. WILENSKY: I would like to see if we can't focus a little more on best practices. Now I don't think it's something you're going to be able to do between now and our June report, but maybe thinking about as we go ahead -- this is an area where we historically have not spent a lot of time. I am sure, without looking, that we will find substantial variation in terms of compliance and complications and best practices.

I'm just concerned that we not take the same kind of attitude that we're adopting for the rest of health care in the Medicare population towards this population. Because if anything, they're especially sick, use lots of health care, use lots of pharmaceuticals. So all the issues that we raised yesterday and that we'll get back to the end of the day in terms of quality and traditional Medicare, seems to be very important.

So it's really more this mindset that not that there aren't reasons that you have compliance problems, or that patient characteristics may make some of the compliance more difficult to resolve than others, but to see whether or not we can try to pinpoint better where the difficulties are, whether there are -- I don't know what kind of data is available. Maybe making recommendations that if we're going to get a handle on improving quality in this area we need different kind of data, we need different kinds of studies or analysis.

DR. LAVE: We seem to have been moving back to recommendation --

DR. WILENSKY: Are these issues --

MS. RAY: I actually have two more slides.

DR. WILENSKY: Why don't we go through the two more slides?

MS. RAY: I actually want to just take an aside and bring up -- because somebody mentioned about increasing the composite rate. I just wanted to bring up the findings of a survey that Johns Hopkins University has just completed. They surveyed renal administrators throughout

the country, and they posed a hypothetical question to them. If the composite rate was increased by 20 percent, what would you most likely do?

The most frequent answers were, number one, improve patient education programs. Number two, improve amenities. Number three, purchase new dialysis equipment. And they would least likely decrease the number of times dialyzers were re-used.

To the hypothetical question of a 20 percent decrease in reimbursement they responded, number one, that they would limit staff salary. Number two, decrease the number of nursing staff. Number three, not replace dialysis equipment.

So the reason why I bring this up is because I think the multi-tiered composite rate is addressing a different issue than the increase in the composite rate. The multi-tiered composite rate -- and yes, I acknowledge that it would be very challenging to put that into effect, but it addresses the issue that each patient is different, and a single composite rate does not address --

DR. ROWE: But Nancy, isn't it just a -- I mean,

it's a form of risk adjustment.

DR. NEWHOUSE: Those words come to mind.

DR. WILENSKY: Yes.

DR. LEWERS: Right.

DR. WILENSKY: It's a different medical price --

DR. ROWE: That's fine, and I'm all for that in fact. But if we roll back the tape to our last meeting of when the risk adjustment for the health plans was discussed by Dr. Berenson and his colleagues, which I thought was an excellent -- Gail said the best they could have done in that circumstance, and evenly and slowly implemented, and everything else. But the facts are, the health plans see it as a way to reduce payments by a couple percent.

DR. WILENSKY: But this would presumably be budget neutral within --

DR. ROWE: Those words are not in this document.

DR. WILENSKY: No. We can put them in there, but unlike the issue with regard to the health plans on risk adjustment is that when you risk adjust, if in fact there is favorable selection in favor of the health plans vis-a-vis traditional Medicare, the expectation at the end of risk

adjustment is that you would have less in the aggregate going to the health plan as a result of risk adjustment.

DR. ROWE: I understand that.

DR. WILENSKY: In this, if you're going to differentiate the payment, there isn't any -- because in fact it's not risk adjustment.

DR. NEWHOUSE: It's all within the same population.

DR. WILENSKY: This is all within the same population.

DR. ROWE: I understand that, but --

DR. WILENSKY: We even put it in there.

DR. ROWE: I understand that completely and I agree with that. I'm just saying that given when has happened recently in this field out of the same federal agency associated with risk adjustment, it's --

DR. WILENSKY: It's not a good analogy. It's not a good analogy on the grounds that the nature of risk adjustment to the aggregate Medicare population is that if it turned out that the health plans had the sicker, you would have a net inflow of money in. And if turns out,

according to any measurable statistics, they had a more favorable population, you would expect a flow out.

This isn't risk adjustment. You can think about it as a medical classification system.

DR. CURRERI: This is recoding.

DR. WILENSKY: But it isn't a risk adjustment. There's not attempt to try to measure the risk between this population and the rest of Medicare. It is to try to differentiate the population --

DR. LAVE: It's like a DRG-based payment system.

DR. NEWHOUSE: -- think of risk adjustment that way. You're matching cost, expected cost to --

DR. WILENSKY: But if you want to on this one, when we make that recommendation, you can put in budget neutral.

DR. CURRERI: It's really just recoding.

DR. WILENSKY: I don't think it's a very good analogy.

DR. ROWE: I think it's led to -- the lack of specificity with respect to the intent has led to the confusion in our discussion. And I think if we're having

this confusion, the field will have the confusion -- of a difference between a change in the composite rate, up or down, and the implementation of a multi-tiered composite rate.

DR. WILENSKY: We've already made the first recommendation. We have already recommended a 2.7 percent increase.

MS. RAY: Yes.

DR. ROWE: I understand that.

MS. RAY: Okay, let me move on.

Despite the increase in case mix of the ESRD population, survival has improved steadily since the 1980s. One to --

DR. NEWHOUSE: Nancy, can I ask a question about that? You have a table in our chart that shows an adjusted death rate fall from '88 to '95 of 20 percent, which is an enormous change in mortality rate.

MS. RAY: Yes, that was the --

DR. NEWHOUSE: And you don't say much about what you think caused the 20 percent decline in seven years.

MS. RAY: I do think if you look at the dialysis

dose, there has been a trend towards increasing dialysis dose within this same period, and I would attribute some of that to the increase in dialysis, of dialysis dose.

DR. CURRERI: What happens to the patient who gets a kidney transplant in these figures? Because I would expect increased number of kidney transplants would improve mortality over time.

DR. LEWERS: They're not talking about that.

MS. RAY: Right.

DR. NEWHOUSE: No, this is page 12 of the handout.

DR. LEWERS: But I think you pulled out the transplant patients, didn't you?

MS. RAY: Right. Yes, that data is from USRDS. Actually, the rate of kidney transplantation has been pretty steady. There hasn't been an increase.

DR. ROWE: My guess would be -- I don't know if we have the data on this, but my guess would be that this is treatment of cardiovascular disease. We know that mortality, life expectancy has increased and mortality and cardiovascular disease has been reduced fairly dramatically, with angioplasties, and stents, and more coronary -- and you

know, what have you. And this is a patient population which is heavily adversely selected for cardiovascular. 40 percent of these people are diabetic. Many of them are hypertensive. These patients have a lot of cardiovascular problems.

So this would be an enriched population to benefit from the technology of cardiovascular intervention. So I would think that analysis --

DR. WILENSKY: Undoubtedly that's playing a role. Cardiovascular has come down tremendously. But this is even faster -- a steep rate of decline.

DR. ROWE: I understand.

DR. MYERS: Could some of it be epo?

DR. LEWERS: It's a multifactorial thing.

DR. ROWE: Because of the selection.

DR. LEWERS: It's epo, it's cardiovascular, it's the control of hypertension, and increased dialysis.

MR. MacBAIN: It appears from looking at the table it does include transplants. It says, survival of dialysis and transplant patients has improved steadily in the '90s. That's the introduction to the table. So my inference is it

does include transplants.

DR. ROWE: Have transplantation rates changed?

DR. WILENSKY: Nancy said that transplants --

MS. RAY: I'm sorry, this is incidence of ESRD patients, so I believe this actually could include transplant patients.

DR. NEWHOUSE: That's what you say at the top. That's what it says right above the table.

DR. CURRERI: But survival is markedly improved. I don't know whether volume is increased, but survival is markedly improved in transplants.

MR. MacBAIN: But is it a big enough share of its own ESRD patients?

DR. LEWERS: It needs to be clarified.

DR. NEWHOUSE: The text says --

DR. LEWERS: I know. I saw that. I thought it had been pulled though.

MS. RAY: Cardiovascular deaths do account for half of all deaths. A little information. What I'm proposing here is future research. And this was actually brought up before about the compliance issue, that little

information about the role of psychosocial factors is known in their relationship with mortality. It may clearly affect mortality. Nearly one out of every five patients withdraws from dialysis before death, and that's based on information reported by the USRDS.

Additionally, another study found that dialysis patients had higher rates of hospital admission for mental disorders than patients with other chronic and systemic diseases.

The Commission can choose to explore this area and do additional research into the risk of mortality due to psychosocial factors among dialysis patients. This may lead to eventual recommendations about the additional need for nurses and social workers as well as patient education.

Finally, research has suggested that mortality rates among ESRD patients in the U.S. are 20 to 50 percent higher than in other countries. The question is, is this a statistical artifact? Is this a fair comparison? We take patients who are older, we take patients who have lots of systemic diseases like diabetes.

There have been certain studies, however, that

have attempted to control for the difference in case mix and have attempted to control for different practice patterns, and this mortality difference remains. I'd like to just briefly -- there's a study published that compared mortality rates among dialysis patients in Detroit and compared them to dialysis patients in Canada.

Mortality rates were found 47 percent greater among the U.S. patients than among the Canadian patients. There were differences, particularly in the prevalence of hypertension and COPD among the U.S. patients, and re-use was not practiced among the Canadian patients.

So there is no one answer. There has been no one conclusive study about comparing U.S. mortality rates to international rates.

DR. WILENSKY: Those are extraordinarily different populations. Having grown up in Detroit, the notion of comparing --

DR. ROWE: Windsor, Ontario is a long way from Detroit.

MS. RAY: But rates of diabetes were comparable. The demographic makeup was not as different as you would

expect it to be.

DR. LAVE: But you're talking about Manitoba. Manitoba has probably one minority of a different race --

DR. MYERS: Why should a minority have a higher rate just on the basis of being a minority?

DR. LAVE: I would imagine that the income differences would be --

DR. WILENSKY: The question is, did you control of income, education, socioeconomic differences, otherwise --

DR. LAVE: I can't imagine they could control for income and education --

MS. RAY: They did.

DR. WILENSKY: Because Detroit and Canada by itself is not an obvious comparison.

DR. LEWERS: Can I comment on that? First of all, you're not going to sit here today and solve the problem of the fourth bullet. There are a lot of reasons why the changes are, and I don't know the difference between Detroit and Canada. But I can tell you right now that in many areas there is voluntary reporting in these areas and not mandatory reporting as there is in the United States.

Higher reimbursement rates occur, particularly in Japan, and have better rates.

The renal community has decided that this needs to be answered, so one of the manufacturers has funded and is beginning a study right now that will be done. It is carefully controlled as to look at the various areas and other parts of the world, and it will include this. So that research is underway and should be available. I don't know the time frame, I've forgotten what the time frame -- but that question is going to be answered. Research is needed, but that study is underway. And it's going to be a huge study and hopefully will put this to rest for us.

DR. LAVE: Who's doing the study?

DR. WILENSKY: Who's actually carrying it out, do you remember? Could you get us some information --

DR. LEWERS: I can get some information on it. I'd rather not mention the name of the company at this point.

DR. WILENSKY: No, I meant the researchers. I don't care who's sponsoring it.

DR. LEWERS: I'd have to get you that.

DR. ROWE: I think the question is whether this estimate --

DR. LEWERS: The Renal Physicians Association has all that information. They've been involved in it.

DR. ROWE: -- whether this estimate includes the recent reduction in mortality rate that we talked about two minutes ago on the prior slide, or whether this is based on data from before this recent 20 percent reduction in U.S. mortality. Do you know, Nancy?

MS. RAY: Probably the most recent data that it's based on is from the early '90s at this point.

DR. WILENSKY: So it's probably not then.

DR. ROWE: So it may be less.

DR. LEWERS: I don't think it is.

MS. RAY: Right.

DR. LAVE: But on the other hand, you'd expect a decrease in death rates --

DR. NEWHOUSE: And the rest of the world may be coming down, too.

DR. LAVE: -- in other countries.

DR. MYERS: The study that you referred to was

published in '97. Where was it published?

MS. RAY: I think it's published in Medical Care. I have a copy of it. I could forward it to you.

DR. MYERS: I don't think we should dismiss this. I think it's something that we really need to think about how the Medicare program should better understand what these mortality differences are due to, and then that understanding should influence the decisions as to whether or not the right solution is the one we're proposing or a different solution. 47 percent is a big number, and we need to really understand what's behind that an adjust our system in order to optimize it.

So I think there's clearly an indication for doing that kind of research.

DR. WILENSKY: I have Judy, Peter, and Gerry.

DR. NEWHOUSE: We still have one more slide.

DR. WILENSKY: Why don't you go ahead, Nancy?

MS. RAY: Okay. Just very, very briefly. BBA '97 required the Secretary to measure and report on the quality of Medicare dialysis service. They were actually in their HCFA core indicator project, among other projects. But to

address BBA '97, HCFA went ahead and has created clinical performance measures. These measures were actually constructed in part using the guidelines already created by the National Kidney Foundation DOQI guidelines. There are clinical performance measures on hemodialysis adequacy, peritoneal adequacy, vascular access, and anemia management.

There's a proposed recommendation about saying what a good thing this is and I guess complimenting the Secretary's efforts. And HCFA right now, I believe, is gathering information about these performance measures for a similar sample of patients that they have previously collected data on in the core indicator project.

There is the potential that these performance measure data will be eventually, possibly collected for all patients, and that facility-specific data could then be provided both to facility as well as potentially to patients. But I think that's a long way down the road.

That's it.

DR. WILENSKY: I have Judy, Peter, Gerry. When you're talking about this, you may want to talk about -- we've raised the issue a number of times of various studies

that we think need to be done. As you make that comment try to do it -- why don't you put that last slide back up, just in terms so people can, when they're talking about other studies, remember -- at least look for a moment at the studies that are already underway or already requested.

After we have time to discuss some of the issues that have been raised, why don't we go back and take each of the recommendations one by one. Judy?

DR. LAVE: The issue that I have is basically concerned with the international comparison and the recommendations for changing the composite rate. My sense is that HCFA has a lot of quality studies underway and has a lot of fairly good people doing that. So I don't know that we can really add too much other than to support what they have.

I was very curious. You know, I do read all the literature that gets sent to me by the interest groups and there was somebody who was writing in this area and was talking about the dialysis policy in Japan, which as I understood it was sort of a fixed payment and then a marginal payment associated with the time of the dialysis.

As I thought about that, that struck me -- not knowing too much about it, but knowing that time seems to be an important issue, wondering whether or not that that approach might make more sense than a multiple composite approach. It would be easier and quicker to initiate and would seem to target directly something that everybody seems to be concerned about; that is, time. And there are people here who could worry about that.

So that was sort of another suggestion or a different approach to modifying the rate that would make it somewhat sensitive to the characteristics of the patient. If time happened to be the critical factor I couldn't see what we wouldn't want -- why would we want to do something very indirectly when we could have a direct approach?

That led to the second thought, and that is that the data -- and this may come up with Ted's stuff, but I think it would also be fairly informative. That would be to actually try to get a sense for how other countries have actually handled this problem. Are there any other countries which in fact addresses as a fee-for-service issue, which is what we really do in this country? I don't

know whether the Canadians address it as a fee-for-service issue or whether what they do is they basically pay the dialysis facilities and then the dialysis facilities do whatever they do.

So I think it would be interesting to actually sort of know how other countries -- it would be an easy thing to do. If people do a dialysis payment or a payment per dialysis, is it a flat rate? Is it like the Japanese system? How have they tried to modify this so in fact it would be consistent with the -- so we could find out whether or not in fact there is an effort to modify the payment according to the characteristics of the patients.

It just struck me that that may be sort of a quicker way to jump start how we might want to think about modifying the rates.

DR. KEMPER: I really just had a question about, when you talk about quality improvement, disease management is part of the litany, and you hear asthmas and diabetes, but I don't hear ESRD. Is anything doing anything along those lines, or is that really the physician -- it's really done by physicians, the sort of management of the cases?

MS. RAY: Up until this point Medicare was the primary payer of ESRD. Now that MSP has been extended to 30 months, that's going to change to a certain degree, at least for the first 30 months of their dialysis therapy. The degree to which commercial programs will put into effect disease management programs, I don't know the magnitude of that. I would expect that to happen.

DR. LEWERS: I don't think there's any national program for disease management, if I understand what you're speaking about. There are pockets of areas where --

DR. KEMPER: So there are examples.

DR. LEWERS: -- there's some of that going on. But I don't think there's any national focus on it.

MR. SHEA: What's our schedule on making a recommendation? Do we have one? Or our review? Aren't we supposed to report?

DR. WILENSKY: Yes, June 1st.

MR. SHEA: So this will be in the June report?

DR. WILENSKY: Oh, yes.

MR. SHEA: I'm sorry. I thought maybe we were talking about a separate --

DR. WILENSKY: No, what we did here, and Murray and I had this discussion, and I think I also may have had it with Joe. We included a very brief chapter, but with a recommendation of a 2.7 percent increase in the composite rate in our March 1st report, and agreed to take on some of the broader quality issues in the June 1st report as part of the broader report.

We had thought about postponing the rate increase recommendation from the March 1st until the June report because we hadn't spent very much on these other issues. I had decided not to do that because I thought it was bad to set a precedent of having the rate increase in the June report when we had already made a decision we thought we ought to increase it.

So these are recommendations that, to the extent we support them, will be in our June 1st report. We don't have a separate report on this issue.

MR. SHEA: Thank you, Gail. My question was prompted by the observation that I thought this was a very complete discussion and got into some areas at least in depth that we hadn't really talked about before. I found

Ted's remarks and some of the exchanges about the compliance issues and the management of this to be very interesting.

It strikes me that this question about the international comparisons is really important in terms of if we're expected to make a particular recommendation and this is a special request that's been made of us. It seems to me we need to be in a position to be able to say something fairly definitive about the international comparison. I'm not sure we're going to be able to do that by June.

So maybe it is unfortunately going to go down the road of proposing more research, but I'm with Woody, we have to answer these numbers in some way. Maybe we can say, we've looked at them and they don't stand up for these reasons. But I think we have to address that and I think -- not having a plan to do that pretty strongly I think is going to put us in sort of a vulnerable position. That's point number one.

Two, I was struck by how this issue of patient education, counseling, a whole bunch of services in addition to the direct dialysis really seemed to have more prominence in this discussion, at least for me, than I've taken away

before from earlier discussions, and it goes directly I think to the rate issue, particularly given your interesting little survey there about what would you do if you got the 20 percent increase and what would you do if you got the 20 percent decrease, because they go right to the team that works with these patients, obviously. You'd increase patient education on one hand, and you'd hold down salaries and cut nurses on the other.

It just seems to me that's a statement of what's going on here. In addition to all the sort of clinical and technical issues about care. So I think that that really deserves some particular focus.

Then lastly I just wanted to second Judy's point about looking at, at least to the extent that we see international comparisons as being relevant and there's something going on in other places that we could learn from, maybe we should look at the payment rates as well as, Gail, your point about best practices, I think was a good way of sort of framing what we need to be doing here in part, and some international comparisons might be useful there, too.

DR. WILENSKY: I agree with that. The interest I

have in terms of the best practices is that, in general, we see such large variations in terms of how we do things in the U.S. and the outcomes, and while I absolutely agree with trying to see, to the extent we can, what it is that's going on in other countries that appears to be associated with their differential mortality rates and different compliance and different strategies, we know in the end that it gets much more difficult to try to draw lessons because they're so much different that goes on in other countries that to the extent that we can find strong differences and best practices that seem very promising in the U.S., we can try to think about what we need to do in order to replicate them or to have them as the model that we try to incent other groups to go to.

So I regard them as two different ways to try to see whether we can't reduce the mortality rates and increase compliance.

DR. NEWHOUSE: I liked Judy's suggestion, too. That probably won't surprise anybody. But I wanted to ask, what do we know about how commercial firms, commercial insurance pays for dialysis? What's the basis of payment

and how does it --

DR. LAVE: Charges. They pay charges.

DR. ROWE: In the United States, you mean?

DR. NEWHOUSE: Yes. The first 30 months now.

DR. LEWERS: If you have commercial insurance.

DR. NEWHOUSE: If you're employed and you're --

DR. WILENSKY: That's a good question.

MS. RAY: That's a good question. I can look into that. Anecdotally, I've heard that they basically follow Medicare's lead.

DR. LEWERS: Basically, right.

MS. RAY: But I don't have a study to show you that says that.

DR. LEWERS: And as you'd expect, it's variable.

DR. NEWHOUSE: I'm wondering if there's anything to be learned then, if there's variation in the payment. I mean, it may be hard to compare with Medicare because of the time confounding. But if there's variation within the commercial domain. If some insurers pay on the basis of time, are people dialyzed longer, for example?

Second, on the -- this is really a statement for

the record and it goes to the epo rate recommendation. I was an expert in the dispute between Ortho and Amgen on how much of the epo market share was for dialysis. And I don't think there's any conflict, but to avoid any appearance of conflict I'm not even -- I just want to recuse myself from that recommendation.

Then, we didn't say anything about transplants. I'm just wondering if there's any issue with respect to Medicare policy on transplant versus dialysis choice?

DR. LEWERS: Say that again, Joe.

DR. NEWHOUSE: Are there any issues that we should be concerned about in who's getting transplants, or how many transplants there are, as it may or may not be affected by Medicare policies? I mean, I don't know, I'm just asking the question. But this was really focused on dialysis, and occasionally the word transplant wafted across the page and then it went off again.

DR. ROWE: There's overwhelming variables of availability of a graft to transplant.

DR. NEWHOUSE: I understand it's supply-constrained.

DR. ROWE: It's inconceivable to me that a physician would not transplant in an otherwise appropriate transplant candidate if a graft was available because of Medicare payment rates.

DR. NEWHOUSE: So it's just entirely independent of Medicare.

DR. LEWERS: I don't think there's any Medicare policy which is restraining. There's only one policy that I can think of that has a significant impact on the transplants, and that is they only pay for the anti-rejection medications for three years and then they cut them off. And the cost is still there and --

DR. WILENSKY: But it's a supply issue.

DR. LEWERS: But that's the whole thing.

DR. WILENSKY: We don't want to get into that.

DR. LEWERS: It's organ donation that is the problem.

DR. WILENSKY: We don't want to get into that, unless somebody asks us to.

DR. MYERS: But Joe's right, it's more than just supply. I mean, there are studies that show, for instance,

a racial difference in those patients that are referred for kidney transplant versus those that aren't. I can't quote you whether there were other variables that were included in that analysis or what effect those variables had, but the dominant message of those studies was that there was a racial difference.

If there is something within Medicare that affects that issue, I don't know what it is, but it clearly would be relevant --

DR. WILENSKY: I don't think there's --

DR. MYERS: I don't know if Joe's got any other variables that --

DR. NEWHOUSE: No, this is an area I don't know much about so I'm really just asking if I should be concerned or not.

Then the last issue I wanted to raise was the last time I recall visiting the issue of margins we didn't think we had any decent numbers because we didn't have any audited cost reports. I'm wondering, (a) is that still the case? And (b), if we had even some numbers we believed on cost at the facility level could we try to tie that -- a research

project to try to tie that to clinical performance?

MS. RAY: To address your first question, to the best of my knowledge we still don't have any audited --

DR. NEWHOUSE: Shouldn't we, by the way, then go back to our old recommendation to spend some money to get some audited cost reports for these facilities?

MS. RAY: I think that recommendation has been made and you can definitely consider making that again, absolutely. I think that's an interesting research question that you've brought up.

DR. LAVE: We have the issue when we get to the audited cost reports and the revenue one, the problem that basically Nancy just indicated. That is, that if you pay less, people are going to decrease their costs by doing things that we may not like. They're going to -- what are they going to do? They're going to decrease their staff salaries.

DR. WILENSKY: That's what they say. But let's see what they do.

DR. NEWHOUSE: I want to know what they're actually spending the money -- I'd like some information in

the way of detail on the cost report of actually what the money --

DR. LAVE: So you're not interested in the number, you're interested in the structure of the cost?

DR. NEWHOUSE: Yes. And how that might relate to performance.

DR. CURRERI: One of the things though that concerns me about that is one of the reductions could be in the number of dialysis done. And I don't know whether we get that in a cost report, because you wouldn't know.

DR. NEWHOUSE: Maybe we want to look at what we do get on the cost report and make some suggestions about what we think we ought to --

DR. CURRERI: It's possible for me to think that they might be doing three dialysis a week when they really think they should do four or five, and that you wouldn't see in a cost report because they're collecting the maximum and that reduction wouldn't show up -- a reduction in the number of dialysis.

DR. NEWHOUSE: You could presumably link that to the claims information system.

DR. LAVE: One of the people we may want to have come in and talk, is it Phil Held who manages the UNIS database system?

DR. NEWHOUSE: Yes, that's the name.

MS. RAY: USRDS.

DR. LAVE: The USRDS database system. And a lot of the things, some of the things that we're talking about they do almost as a matter of course.

MS. RAY: Yes, they do.

DR. LAVE: So I think it might be useful sometime to have him come in. Because I think he looks at some of these things.

MS. RAY: He does, and he's actually looked into the international comparison a great deal. Yes, he has.

DR. WILENSKY: Maybe for whatever we have in the June report, you take what is available and can share with us, based on some of the comments that have been made today, and it may be that one of the things that we have for our fall activity, if we decide we want to have some additional concentration in this area for next year, is to have as one of the sessions that he come in and we discuss some of these

issues.

DR. LEWERS: What I'd like to do, Gail, is just give some general comments on the chapter and then come back in the recommendations.

DR. WILENSKY: Okay, because we do need to go through these recommendations.

DR. LEWERS: To Judy, you said fee-for-service. This is the most capitated program we've had in history.

DR. LAVE: No, but we pay for every dialysis. Or we pay for three a week.

DR. LEWERS: But still it's a capitated system, but in many ways -- we can talk about that later. We don't have time for that.

The other point that's not -- one of the factors that's not included in this chapter that I'd like to see some discussion is early dialysis and early referral.

One of the problems we have, and we've been seeing it more and more as managed grows, is late referral of patients. I used to see them fairly early. Well, I don't see them now, but in the past they just didn't come in early. And you need these patients early. We finally broke

through with diabetics and got permission for early dialysis from the program on that, but it is not the case. And that's also in some of the other countries where that's a factor. So I'd like to see some --

DR. WILENSKY: Is this under or over 65 population?

DR. LEWERS: It's in the whole population, but it is in the whole group.

DR. WILENSKY: Just because in the over-65 population there isn't much managed care, so I'd be surprised if that's going on in the Medicare --

DR. LEWERS: But there's a number of factors that impact that. If I'm 60 and I've got renal failure with a creatinine of two-and-a-half or three, I ought to be in the hands of a nephrologist to begin the process. And that's going to impact what happens to me when I go on dialysis at 67.

So I think that this total picture -- and we have to hold these patients back and wait for their creatinines to get to a certain level before we can put them on dialysis because they won't be compensated, even over 65. So early

dialysis, the whole subject, is something I think we need to put some information on.

MR. SHEA: Ted, you're raising a question about practices in managed care or something about policy?

DR. LEWERS: What I am saying is that overall the early referral of a patient with chronic renal failure is delayed and we've been seeing an increase in that delay in recent years. There's not a good study that I have seen to tell me that that is a systematic thing. But if you talk to every nephrologist they'll tell you that.

That early on, when I first got into nephrology, seeing patients referred with creatinines with 15 and 16 and uremic pericarditis and all was commonplace. That disappeared and all of a sudden you're beginning to see those higher creatinines when the patient first gets to you. And that, in relationship as well, to putting the patient on dialysis, at what stage do you put that patient on dialysis and the policies that are involved there.

The earlier you can get the patient on dialysis, the better the end result is going to be, the better the mortality, the less comorbidity, et cetera. So that's the

area that I'm looking at, Gail.

DR. WILENSKY: I'm a little concerned if we don't have good studies about what's going on in the west -- I mean, I certainly wouldn't object to having any information.

DR. LEWERS: There are studies. I'm just asking, Nancy, that I think that we need to consider putting some of that in the chapter. I'm not talking necessarily at this point about a recommendation. But I'm talking about at least looking at some of the material that's available.

DR. ROWE: Let me ask a question, because I think I'm hearing two things, at least in the questions from our colleagues.

One question is putting patients on dialysis earlier, when they have lower levels of creatinine, BUN, or whatever, because that might be better in terms of quality of life, et cetera.

The other question is referring patients to nephrologists earlier in the course of their renal disease for management, which may delay the onset of dialysis. So these are two separate -- the first question may be a Medicare policy question with respect to approval. The

second question is a practice pattern question which is really beyond Medicare policy.

DR. LEWERS: I understand that, but I'm trying to give some information that I think Nancy should be taking a look at, and I'm trying to do it in a hurry because we're going to be late and I've got a lot of things I want to talk about.

[Laughter.]

DR. LEWERS: Just trust me.

DR. ROWE: I trust me.

DR. LEWERS: The checks' in the mail. It works.

DR. NEWHOUSE: He trusts, but he wants to verify.

DR. LEWERS: The other points, general comments. In the chapter, there are a number of statements that you make that you do not put documentation. I think you need to document that. There's an area where you talk about creatinine as a mortality predictor. I disagree with that. There is not really good evidence of that. If you've got that sort of thing, document.

Secondly, is one of the areas where we've all talked about. We've got a ton of information, and I've been

saying for five years, this is a program that has more information available but is not getting in the hands of the right people. We need an infrastructure for the material to be reported. We need a public/private partnership to do this.

The industry, the manufacturers, the providers are supporting a lot of studies that are going on here, and I think that HCFA should cooperate and work with that industry. There is some cooperation that's going on with an organization called the Forum, which is to be encouraged. But I think that even a recommendation that HCFA consider further cooperation.

I think we're short in the chapter on comorbid conditions and their role in morbidity and mortality. I would like us to take a look at the literature on daily dialysis and see if it is something that we begin to mention. I do not think we recommend, at this point, but I think that this is an area that there is work coming in that they get off of antihypertensive medication, their epo dose decreases, their quality of life increases, their hospitalization decreases. So there's information available

and we need to do that.

The other two factors, just briefly, on the total of the chapter. Staffing patterns and techs versus nurses. I don't know that that has any role to play in mortality, morbidity, or anything that we're doing in this country. I've worked with these people for years, they're dedicated people. I have not seen a decrease in the quality of care related to that, and I sort of got that impression. I don't think you mean that but I think you should take a look at the working to make sure that's not the case.

And re-use is another topic all to itself. If I were to go on dialysis today, I would want re-used kidneys for me. The data that I have and me experience, and it's extensive, that we've been working on for years, tells me that my patients have a lower mortality when I use re-use.

You know, there's an end point where you don't need to go to 60 dialyses to make it for money, but I would prefer re-use. And actually, in my programs, when I was actively running them, we re-used every kidney before I put the patient on it. I put it through the re-use process.

So I don't want to see us knocking re-use unless

you've got good evidence for you to knock it. And I'll comment on the others later, Gail.

MS. NEWPORT: I think everybody has just agreed with the notion that we need to understand the international differences to what we're doing here.

On the quality side, I think it's a very interesting discussion and confirms some thoughts that we've been having. Best practices versus compliance, and there's some very relatively cost effective things that you can do in the education area that can help your quality going forward. So I think it's important to link that, but also distinguish the differences, because I think sometimes in measuring, and when you have metrics, you confuse the two.

So is it a good quality delivering of services versus then the extra steps that you can take to make sure that people can manage their care or the providers can help them forward.

I think in going forward, you establish a baseline of measuring quality. I think that's important and I think we've sort of referred to it here, is that improvement can be taken at variable levels. Later on 1 percent improvement

can be more costly than the whole program all together, leaping to an extreme there. And I think that it's important to understand that continuous improvement will come in smaller and smaller increments as you go forward. And I think a lot of folks in the public sector don't understand how difficult it can be going forward.

Measuring that, I think, is important and how we recommend HCFA distinguish the levels of improvement that we can extract from any system.

And I have a question about the reimbursement but I'll save that to the recommendations section, if that's all right.

DR. ROWE: I have one question. In the prior discussions when we asked why was it that HCFA didn't increase the rate. One of the things that came up that I found really interesting was well gee, from an economic point of view, there was still market entry. There was still people entering this market.

DR. WILENSKY: That has been the response of HCFA and the IG over the last extended period.

DR. ROWE: Right, and I found that really

interesting. I just wondered what we knew about whether that was still the case? Do we know, is there still new market entry in this field?

DR. WILENSKY: I don't think there's any decrease.

MS. RAY: I would have to follow up on that with you.

DR. ROWE: That would be very interesting.

MR. MacBAIN: I wonder if we ought to take a closer look at this whole issue of compliance? The thought keeps running through my head that we might add a recommendation that HCFA fund some pilot projects, call for some proposals from dialysis centers, to test a variety of different approaches, whether it's along the standard disease management approach or Ted's idea of finding model patients and equipping them to educate, exhort, and encourage their fellows.

It seems to me there's some opportunities there that we could really -- it may be the one area in this where we really could see some significant improvements and it's probably worth encouraging some pilot work.

DR. NEWHOUSE: Maybe we want to do that through

the QIOs, as a possible --

MR. MacBAIN: I don't know how to structure it, but I would like to say to HCFA that HCFA should --

DR. NEWHOUSE: I was just thinking that HCFA's demonstration budget is so strapped that putting it there is probably putting it nowhere.

MS. NEWPORT: We could lend them some money from the competitive bidding.

[Laughter.]

DR. WILENSKY: We can put that as one possibility, although the preferred way would be a HCFA demo.

DR. NEWHOUSE: But you could do both actually.

MR. MacBAIN: The point is, and I think we should make it strong enough, that we think this is something that ought to happen. Eventually if it works, it gets funded out of lower DRG payments for admissions.

DR. LONG: Just a question. A thought occurred to me, obviously there are some people out there whose onset of renal failure has occurred while they were enrolled in a risk plan. Do we know anything about those people? How many there were? Anything about treatment patterns there?

Or their outcomes as compared to people in traditional Medicare?

And what happens to those people? Do they ultimately disenroll?

DR. WILENSKY: There's a capitation experiment that is going on, but except for this capitation experiment, people as soon as their eligible for Medicare --

DR. LAVE: They age in to --

DR. WILENSKY: I know, but my point is up until now you've not been able to stay in a risk plan.

DR. LONG: I know you couldn't enroll, but I thought you could stay in.

DR. NEWHOUSE: It started, say you were in Kaiser and --

MS. NEWPORT: You can't enroll them.

DR. NEWHOUSE: -- your kidneys fail, you don't have to leave, no.

DR. WILENSKY: Okay, I thought you had to. There was also a capitation experiment.

MS. NEWPORT: If they become eligible after that, they stay with us. I can give you our numbers.

DR. NEWHOUSE: In fact the last ProPAC, we had a presentation from Kaiser on how they manage their dialysis patients.

MS. RAY: Right. I can follow up with you and get back to you on that. I think that's a good question.

MS. NEWPORT: We may have some studies, too, internally that I'll ask our medical directors on that.

MS. RAY: I'd appreciate that.

DR. LAVE: I have a question. This is a question -- I have two questions. The reason I said a fee-for-service for dialysis was that I thought that every time the patient was dialyzed, up to three times a week, the dialysis facility got a patient for doing that dialysis.

DR. WILENSKY: It's a bundled payment.

DR. LAVE: It's a bundled payment, but I was defining the service as a dialysis.

DR. WILENSKY: No, it's definitely not capitated, it's just a bundled payment.

DR. LAVE: So the second question is but the nephrologist is a capitated person. Can you explain a little bit about -- that's how the facility gets paid. The

nephrologist gets paid for taking care of the patient. And what services under the capitated payment is the nephrologist supposed to be providing?

In all of this conversation, we have talked only about the dialysis payment. Should there be any reason that we should be thinking about the nephrologist payment as well? Because the nephrologist is separate from the dialysis.

DR. LEWERS: That basically is a monthly capitated fee. If the patient goes in the hospital, that can be either deducted or you can bill that system. So that is a system, when you care for the patient there are a few things that you can charge for extra in your office, but not that much. So it basically is a capitated program.

And I look at the fact --

DR. LAVE: That is capitated.

DR. LEWERS: But I look at the fact that yes, there's a bundled fee as a form of capitation.

DR. LAVE: It's a matter of terminology.

DR. LEWERS: It is a dialysis issue.

DR. LAVE: Is there any reason that we should be

thinking, since we've never talked about it I guess I'm raising it. Is there any reason that we should be thinking about the way then that the nephrologist is paid in this, or should we -- as we have always done -- just sort of ignore that whole issue and focus on the way the dialysis facility is paid?

DR. LEWERS: I think you heard my feelings on looking at how physicians are paid is an area that we need to spend more time on, in general. And perhaps that should be. I don't think that's an area that I -- I'm not hearing any grumbling out there. They're not calling me and saying change it.

DR. LAVE: Okay. That's all.

DR. LEWERS: I was very comfortable with it when I was collecting it.

DR. WILENSKY: Let me go back to the series of recommendations and see how the commission feels about them.

DR. LEWERS: Did you take Bill's as a recommendation? Because I wanted to comment about that.

DR. WILENSKY: We'll come back to that when we get through with the stated recommendations, I'll raise that and

I would put that as one of the proposed new recommendations if we want to go do that.

On page three, the first is that we suggest Congress create a multi-tiered composite rate. Let me just make a suggestion that that seems to me a little strong, given that we don't really know what we're talking about. On the grounds that we haven't seen very much.

I mean, it's an interesting idea and I want to propose that either we direct HCFA to look at this, or that we do some more work. I don't want to dismiss it. But it seems to me that we have not done very much homework to suggest the creation, so that we either ought to direct HCFA or the Secretary -- if we think this is a promising idea -- to explore the implications of a budget neutral multi-tiered composite rate as a way to encourage more appropriate behavior among other strategies.

DR. CURRERI: To me this is the same as expanding the DRGs within a group, so that you can get more space --

DR. WILENSKY: It is a sophistication of the medical classification system.

DR. MYERS: I would agree and I would also wonder

if Judy's comments can be taken with that. In other words, the time related patient issue, whether or not there's also a way to do this that's related to the time that's spent.

DR. WILENSKY: I think if we suggested re-looking at the structure of the payment, including a multi-tiered approach or partial capitation effectively, that is a component that reflects time use as well as a base payment, among ways to change the incentives associated with the payment.

But I just feel like there are too many things we don't know at this stage and haven't thought through what are the implications, what kind of behavior change, to make that a suggestion.

DR. LAVE: I think we should change the recommendation to say something like that Medicare suggests that HCFA study the development of an alternative approach to setting dialysis payments that would be a variation of either a DRG-type payment or a -- I mean, I think we want to give a number of things.

And I guess the question that I have or the problem that I have is that to some extent that that is

different from a proposal that suggests that the number of dialysis sessions per week or the limit on the number of dialysis sessions per week should be changed. I'm not sure that you want to put the number of dialysis in with the dialysis payment rates.

So I think you may want to think of them maybe together, but perhaps also separately if that is as an important an issue.

And I guess the question that I have, Ted, is that if one did that and made sort of a time-based payment, then you would have -- if you did it more often, do you do it for a shorter period of time? So would you do say four two-hours a week as opposed to two three-hours a week? You get more time on aggregate but each session is a little shorter?

So if you had sort of a fixed and variable cost associated with time, then maybe you could put that together with multiple times per week?

DR. LEWERS: There are a number of studies that have been done on this and this factor of a shorter dialysis and doing it more doesn't appear to be the way to go. In the first short period of time of dialysis you can lower --

just to put it simply -- lower the BUN down to a level. But the point is that when you stop it comes right back up.

So the more gentle the dialysis, the longer the flow of the dialysis, the more of the toxic substance you're removing. That's why many people say the peritoneal dialysis, the continual ambulatory peritoneal dialysis, works so well, because you're constantly lowering that.

So there's been the short dialysis and there's been the long and I think we're getting now away from the short dialysis and I wouldn't want to see us back in that.

DR. LAVE: I was just wondering whether or not if it was more you did it shorter but it's more longer -- okay.

MR. MacBAIN: The purpose for doing this put forward by staff is that if more complex patients generate a higher reimbursement, that they'll also receive a greater quantity of service, which implies that less complex patients will receive a lower quantity of service if it's a budget neutral program. And I'm not sure that we have any evidence that suggests that would be a good thing.

I'm a little nervous about the downside potential of this, in trying to provide greater funding for more

complex patients.

DR. NEWHOUSE: It may not be only that. It may also be a selection issue, in terms of willingness to accept the complex patients.

MR. MacBAIN: It's not budget neutral for individual dialysis centers. And so we're also potentially redistributing funds for those dialysis centers that find themselves on the short end of this, may cause some access problems. There's a lot that can go wrong with this, for the little that might go right.

DR. WILENSKY: That's why I think this is a much more complicated issue than we're prepared to take up. It's why I think that we need to direct the secretary to look at the options to try to structure a rate that incents behavior that we would like to encourage, but that has an opportunity to look at the issue of if we were to have a multi-tiered, what is this going to do for the centers that have low acuity, relatively low acuity dialysis patients?

I agree, I think this is just too complicated for us to, on the fly, make a recommendation.

DR. LAVE: Can I say something? I don't think

conceptually even that we want to make this as a budget neutral. The reason that I say conceptually we don't want to suggest it as a budget neutral series is the fact that, on average, the thought is at the moment there are a number of people who, in fact, have been under dialyzed. And so to dialyze them more you have to put more resources into the system.

DR. WILENSKY: We have already made a rate increase.

DR. LAVE: So we may want to put it in conjunction with the rate increase, but I think that when we suggested the rate increase we were very concerned that the additional money get put towards what we thought was better care. And this, I think, is a way of tying the better care in with the rate increase.

DR. WILENSKY: It's certainly appropriate to reiterate the raise recommendations were made and ought to be taken in conjunction with the rate increase that we recommended as part of the March 1st report.

DR. CURRERI: But I thought that the rate increase that we recommended was simply to make up for the lack of a

rate increase over the last eight or nine years. And you're really suggesting --

DR. NEWHOUSE: ...inflation last year.

DR. CURRERI: But you're really suggesting more input and --

DR. WILENSKY: I think right now we made a small rate recommendation because we're not in a position, with the amount of work that's been done, to have a basis for making a substantially different recommendation. And when Nancy comes back next month, we are still not going to be in a position to have available the kind of information to suggest this is what we want to do.

Now I think it's appropriate to reiterate that we are recommending a rate increase, that we're concerned about these issues, that we're asking either that studies be done or that the results get reported back to us as they are available, that we're concerned about under dialysis and inappropriate use or lack of use.

But I don't think we're in a position to make -- other than what we've already done -- to make recommendations about more than the rate increase that we've

done. In the first place, it's not a report that is supposed to deal with rate increases. But second, I just don't think we're going to know any more than we knew last month, in terms of what more additional money we want to make available.

I mean, it may well be that when we have all the information available, we would make a much stronger recommendation about expenditures in this area. But I don't think we're going to be there in three weeks. But it's certainly important to remind people that budget neutral within this context at least means the 2.7 percent rate increase that we were talking about before.

DR. LAVE: But do we need to mention the budget neutrality issue? I guess that's really what I'm concerned about.

DR. WILENSKY: We don't need to. It was more to reassure Jack that we weren't taking money out because there was no intention to take it out.

DR. LAVE: I would see it as putting money in.

DR. WILENSKY: So I don't mind not saying it.

DR. ROWE: I'm talking about the dissonance

between what this group intends and what HCFA does. That's all.

DR. LEWERS: I think I agree. I'm not quite sure where you ended up on this recommendation. I would rather see us try to work on this. I am afraid if we just recommend that HCFA just take a look at this, their plate's so full it won't get done. So I would actually pull this recommendation and leave it until we have some information--

DR. NEWHOUSE: You'd recommend that MedPAC study it.

[Laughter.]

DR. LEWERS: I think it's a very interesting concept but I don't think we're there yet. And certainly I would not -- this recommendation is a positive created. We're not ready for that.

DR. WILENSKY: That I agree.

DR. LEWERS: So I would prefer that we just not put this recommendation in.

DR. WILENSKY: Is there a sense of the group that we think this is sufficiently important that it's an issue we wish to take on? That there's a suggestion of suggesting

HCFA would take it on? Is it just, given how full their plate is, that that's not going to go anywhere?

DR. LONG: How full is our plate?

DR. NEWHOUSE: Is it an either/or, I guess is the other question.

DR. WILENSKY: It's certainly not an either/or, but is there a point -- we can clearly recommend that HCFA do that without --

DR. LEWERS: We can recommend they consider it, if you'd feel better in that evaluation, and let them do it. And we continue it, too.

DR. WILENSKY: Okay.

DR. LEWERS: I think it is important enough for us to continue.

DR. WILENSKY: Why don't we continue it as a recommendation to the Secretary that HCFA look at this issue, but it's one that we will regard as one we want to pursue, as well.

Page seven, the recommendation by HCFA and OIG to decrease reimbursement to $9 per 1,000 units.

DR. CURRERI: Why do we want to do this?

DR. WILENSKY: I don't know. I mean, I have --

DR. CURRERI: This is not important. If HCFA's going to do it, let them do it.

DR. WILENSKY: I'm kind of neutral about this.

DR. LEWERS: I think that if there are certain things that we should even comment on it, that we should comment about it's not just the cost of the drug. There are a lot of other factors involved with this drug, and so we've ignored that.

DR. WILENSKY: I just don't feel like it's an area I know enough about.

DR. LEWERS: I don't think it's a key issue.

DR. WILENSKY: Page 10, the Secretary should support research evaluating the efficacy of nutrition in preventions --

DR. LEWERS: You skipped one.

DR. WILENSKY: Sorry. Temporary coverage of enteral feeding, IDPN and IPN, for malnourished dialysis patients. By providing the temporary coverage, does that set a reimbursement level or does that just allow for that to be issued? I gather there was some dispute going on in

the industry that they could not provide nutritional therapy, even if HCFA didn't reimburse it, under present law. And that at least being able to do that -- or does this actually provide for reimbursement?

MS. RAY: I think it would take both a statutory change to put it under the renal, as well as HCFA setting some sort of criteria for its use.

DR. WILENSKY: It would seem to me that we, at the very least, ought to recommend as a first step that the dialysis centers be allowed to provide nutritional therapy, which I gather they are not now allowed to do, even if there's no reimbursement because of an IG issue, an inspector general issue, about providing something for which there is not coverage.

So it seems to me that we might want to consider a two part. It might be a lot easier to get that allowed, and then to take the second issue about whether there's reimbursement.

MS. NEWPORT: Isn't it, at some point, a benefit interpretation that HCFA can make, but I just heard you say something about it takes a statutory change to cover this?

Benefit interpretations, if it moves the best practices forward, is okay.

DR. WILENSKY: My understanding is that the first can be done, HCFA has the authority to do the coverage. It's a question of where it puts that in.

MS. NEWPORT: It's a site of care?

DR. WILENSKY: There's undoubtedly some debate about it, so if we I guess make the recommendation and indicate whether it's an administrative or whether it would require a statutory change, there is -- I have heard it said that it does not require a statutory change.

DR. CURRERI: Why do we have the word temporary in this recommendation? I don't, first of all, know what that means.

DR. LEWERS: How do you define temporary?

DR. CURRERI: And second of all, why shouldn't you cover it if it's needed over a long period of time, chronically?

MS. RAY: I guess the issue, why I used the word temporary, is because there haven't been any big efficacy trials done on these interventions. And that my sense that

I get from the renal community is that they have tried to use these therapies and when they have used them they've been quite successful. However, it hasn't been examined in a double blind, randomized trial.

DR. CURRERI: But it has in other disease states. I mean, there's been hundreds of studies showing the efficacy of correcting malnutrition in chronic disease, and in acute disease for that matter. So whether it has to be done in this particular subset, I don't think there's any question about it.

MR. MacBAIN: Should we combine these two recommendations? Provide coverage and study the result.

DR. WILENSKY: But I do think we ought to make this distinction because I think it's more likely that we could get HCFA to allow for the provision of nutritional therapy, and then to put in the part that has coverage, which presumably has reimbursement, and to do additional studies or whatever.

I would hate to have the continued lack of provision by those centers that are willing to do it even without additional reimbursement. That just seems to be

really hard to justify. That if we put in, indicating also that having levels set for reimbursement for this coverage, they can do that or not. We obviously up the stakes of whether they follow this recommendation once we put in new reimbursement requirements.

So that's the two step that I would like to see.

DR. LAVE: I liked those two steps, too, and the reason is sort of a different reason. It doesn't make sense for me to have a recommendation that provides temporary coverage to begin with.

And the second thing, though, is that I think that as one begins to move into issues of covering nutritional therapy, that I don't believe that the ESRD population is the only population who is at risk for this.

It may be the most concentrated population at risk, but this is a non-trivial issue and I think that it moves towards a major change in coverage issues.

So I think that the idea, first of all, of recommending that if people want to cover it they can do that, it's a perfectly appropriate one, I think doing research is perfectly appropriate, but I think we really

have to be cognizant that this is maybe the most at risk population. But in terms of the aggregate number of people at risk, it's --

DR. WILENSKY: I think that's a good point and it's also a good reason.

DR. CURRERI: But it is important to point out that Medicare does cover nutritional therapy, for instance, for in-patients. I mean, they're built into the DRGs. And so I don't see anything inconsistent with covering something we know is efficacious.

DR. WILENSKY: Somebody in the back trying to make a point. If there's point of fact you want to add, that's fine. If it's a point of opinion, you need to wait until the public comment.

MR. GREER: There's no such distinction, in my opinion, but this is a fact. I think there is a multiple use of the word temporary that is leading to massive confusion.

I'm Joel Greer. I work for HCFA. I do not speak for HCFA. I am a paid employee. I'm not a political appointee. As a matter of fact, they don't allow me to

speak for them, so I'm trying to stick to facts.

The Medicare payment distinction that relates to temporary is between IPN, which is for people who cannot -- who have no gut basically. I'm not a physician, I can't be more precise. And they need it permanently for the rest of their life for 100 percent of their nutrition. That is the covered service that is like having a replacement leg. You have a replacement gut.

What is not covered is nutritional supplements, which is part of your nutrition must be supplemented as it would be if you drank a can or had it put in through your arm or neck, or however it's done. But that's a nutritional supplement and we don't cover nutritional supplements.

That is the Medicare position.

Now the temporary issue is also dialysis patients seldom need it for 100 percent. IDPN is intradialytic, the point being they've already got venous access. Why not add a nutritional supplement? Which they probably do need. That's not the issue.

But here it's a very special case of people who already have access. And that's why IDPN might be a

dialysis issue, hypothesizing.

But I think my basic point is it's a very difficult issue. It has been talked about. I might add that I have never heard that dialysis facilities are prohibited from performing IDPN, it's a coverage.

DR. WILENSKY: Murray and I both had one of the companies visit us who indicated they would like to be able to provide it. It is an IG issue. It is an IG issue for clinical labs, that you cannot provide if there is no charge. They indicated it was an issue here.

So the first part would be as the debate goes on, with regard to whether it should be covered, that there be a first part that says for those centers that wish to cover it, they basically be protected from IG activities because they provide this within the composite rate.

MR. GREER: I have no facts to add on that, so I'll be silent.

DR. WILENSKY: I would like to have as a provision that at least be, since we're told that this is a current prohibition, as I say. I know it's a prohibition with regard to clinical lab. They can't do something for which

there is no charge or coverage.

MS. WILLIAMS: Part B, that's correct.

DR. WILENSKY: So I think that putting this first part in is something that be allowed. And the second part, it be part of an additional study to decide whether or not we want to make a recommendation, understanding what Judy has said with regard to the implications of that type of coverage outside of this program, being our recommendation. And you may want to, in rephrasing that, talk to this gentleman.

The last recommendation, and I believe this is on page 15. I'm not sure, and I'm kind of left blank about having us make a recommendation saying we support what the Secretary's already doing. I mean, I do support it but I don't know whether we need to have that as a statement.

Does anybody wish to have this in or change it or modify it?

MS. NEWPORT: I think I agree with you, Gail, it's a little bit too blanket. It needs a little more distinction.

DR. WILENSKY: I'm not sure what it is that we

add.

DR. LEWERS: I think if you look at Table 2, those studies are ongoing and very important, the clinical performance measure project is an excellent one. And there is some work that is going on. I think that, as I said earlier, I'd like to see a recommendation encouraging the Secretary to have this data infrastructure and work with the private industry in the studies that are ongoing.

So I would propose that some sort of recommendation along this line be attached to this one. That they work the public/private partnership, et cetera. We can word that.

DR. WILENSKY: Maybe you can work with Nancy to see if you can get better wording. As it stands, it's just sort of like atta boy. That's nice. But if we can do something that suggests a modification or an additional effort that is not already ongoing, then I think it would have some use.

There was a question about additional recommendations with regard to the cost report, or any others?

MR. MacBAIN: I would just add a recommendation, I'm not sure where the source would be, but to provide funding for some pilot projects and improving patient compliance.

DR. WILENSKY: Right.

DR. LEWERS: I think of that's already ongoing. I think we ought to take a look at that before we make a recommendation at this point. I think that Nancy and I can take a look at some of the studies.

DR. NEWHOUSE: Is there any reason not to suggest it as a possible QYO target?

DR. LEWERS: No, I would agree with that.

DR. WILENSKY: Can you try to find out whether there's anything already ongoing, and otherwise to have this.

DR. LEWERS: I'll give you an example, I was on a plane the other day sitting next to a gentleman and we were delayed on the runway. And I can tell you, as a nephrologist looking at him, he has chronic renal disease, whether he knows it or not. But he announced, I need to eat, I'm a diabetic. And that was after his second bloody

Mary and three glasses of wine. And then he ate cashews. So we can talk compliance. I know that man had been told otherwise.

DR. WILENSKY: Okay, Nancy, thanks. We look forward to the next version.

DR. ROWE: He wasn't the pilot, right?

[Laughter.]

DR. LEWERS: I normally don't sit next to pilots.

DR. WILENSKY: If people want to leave, do so but do it quietly.

Murray just raised an issue. We have external people for a panel discussion. I think we're going to flip them out of respect for their time, so they don't have to delay it. We'll reverse the order, sorry.

We're going to do managed care for the frail elderly. Sarah and Tim, do you want to introduce the subject and your guests?

MS. THOMAS: Yes. Last September we brought to you a presentation on doing some analysis of three programs for the frail elderly, managed care programs. The Program of All-Inclusive Care for the Elderly, or PACE; the Social

HMO Program; and EverCare, which is a program for people in nursing homes.

At that time, we gave you a work plan and you indicated to us that the first order of business was to look at the issue of payment. So today's session is going to be mostly focusing on that.

I just want to give you a brief overview of the entire chapter, which will cover issues other than payment, in addition to payment. We're going to start with a section that compares the features of the three programs and describes their overlap with Medicare+Choice.

The next section will be on payment methods, first dealing with Medicare. There will be recommendations in that section. And then we've started some early work on thinking about a framework for setting capitation payments for Medicare and PACE, which is the only program that explicitly gets capitation payments from Medicare.

The third section will be on program standards. We're hoping to have some recommendations for you then. There's a few in the appendix to start thinking about. First of all, the issue of performance measures across the

programs. And then thinking about some other issues about eligibility and enrollment and marketing.

Today we're going to first start with a panel discussion and Tim is going to take you through options for Medicare payment for these programs. And we'd like you to come to some preliminary decisions about those recommendations.

And then at the April meeting, we'd like you to finalize the payment recommendations and we'll bring you the program standards issues to look at and hopefully come to an agreement on recommendations. And at that point, you can give us an overview of what you think about the overall chapter.

DR. ROWE: This is for the June report?

MS. THOMAS: This is for the June report.

MR. GREENE: Good morning. The SHMO, EverCare and PACE plans currently receive payments based on modifications of Medicare+Choice rates and tend to reflect the costliness of care to the frail elderly. These risk adjustments play a major role in providing these specialized plans with adequate resources to deliver their particular mix of

services. The level and distribution of payments to the plans will be affected by the risk adjustment methods chosen by HCFA.

This morning the Commission will hear a presentation from our panel members on risk adjustment for the frail elderly. Then, as Sarah indicated, I'll come back and we'll discuss recommendation options for the June report.

The panel this morning presents a discussion on risk adjustment issues, specifically for the frail elderly, not risk adjustment in general. The participants are Lenny Gruenberg on my right, who is a researcher who's been involved in the development of the SHMO programs. He's president of the Long-Term Care Data Institute. Secondly, Greg Pope, at the end of the table, is vice president of the Center for Health Economics Research and Health Economics Research, Incorporated. He's a member that was originally involved in the development of DCGs. He's currently working on a project to study the use of data from the Health of Seniors survey for use in risk adjustment.

Dr. Gruenberg and Mr. Pope will be discussing

recent papers that they've prepared that you have copies of, dealing with risk adjustment for the frail elderly. Lenny?

MR. GRUENBERG: I think I'm going to begin by saying four major points that I'd like to make, and then I'll present some data. The first, just perhaps elaborating a bit on what Mr. Greene said, that the Social HMO and PACE grew during the time of TEFRA and it was recognized that under TEFRA the AAPCC payments did not really adequately reflect people's health status.

Therefore, the Social HMOs and PACE were enabled to experiment with new programs with a modified payment structure that took into account disability level and that was what was necessary really, and what facilitated the development of these programs. That's the first point. I'll present some data that supports that.

The second point is that under the new proposed methods of payment there continues to be an inadequate recognition of the role of disability in influencing Medicare expenditures, so that there will continue to be a need to give special recognition. If we want programs including Social HMOs and PACE, we'll have to continue to

recognize disability level and to include them, in some way, in the payment system.

The third point and the fourth points are something that I want to make more as an after statement, that aren't so much related to what are the major points of today. But I believe that, in addition to that, the Social HMO would not be feasible unless there is some additional payment. In other words, it isn't enough to have only the fair and adequate Medicare contribution to the premium of someone in a Social HMO. I believe that there would be, in addition to that, the need for some additional public contribution. I'm going to just mention that at the end.

Then the fourth point I want to make is that although the topic of today is talking about the payment systems for Social HMO and PACE, I think that the results of the research have important bearing on the payment system for Medicare+Choice. And that's without having some measure of disability taking into account, we're going to have some problems later on down the line in the overall payment system.

In the first slide, without trying to go over the

whole AAPCC, as Mr. Greene mentioned, the Social HMOs and PACE received higher payments for people that were frail, that were so frail that they were nursing home level, that it would be judged in each state that they existed, that Medicaid would be willing to pay for those people in a nursing home if they were admitted. And those people are called NHC or nursing home certifiable. And Medicare paid a rate that was higher to PACE and to Social HMOs.

It was historically developed somewhat differently. PACE gets paid 2.39 times the AAPCC and the Social HMOs get paid something like 2.5 times the AAPCC. These data were taken from a study using actual PACE data where the data from PACE assessments were overlaid over the current beneficiary survey. What we found was that the actual costs of people who looked like PACE recipients but who remained in fee-for-service ranged from two and a half to three-and-a-quarter times as high as the AAPCC.

In fact, there was a systematic change over a three year period where there appeared to be higher -- that Medicare costs were more and more -- increased greater for the NHC population than for other people, and the cost

ratios increased over that period.

DR. NEWHOUSE: Lenny, what was the sample size here?

MR. GRUENBERG: This was a sample of 450. It was essentially all of the PACE members that we had available to us, which at that time I think were 450.

DR. NEWHOUSE: Each year?

MR. GRUENBERG: What we did was we took the 450 PACE members and their assessments and we then took all of the data from that assessment and then overlaid it over the current beneficiary survey. And from that we could then predict what would those people's cost ratio be if they were in fee-for-service.

So we took actually the 450 people in PACE and then we overlaid it over the current beneficiary survey, which was 5,000 people. And we then predicted, on the basis of diagnoses and their functional level, what their costs would be.

DR. NEWHOUSE: I don't understand that.

DR. KEMPER: So how many people in the current beneficiary survey met the criteria for PACE?

DR. LAVE: No, they didn't do that.

DR. NEWHOUSE: They started with PACE people and then somehow there's a --

MR. GRUENBERG: We took the assessment data from PACE and pulled out the comparable variables in the current beneficiary survey that were the same as the assessment data in PACE. We then developed a predictive model, using those variables, of what the Medicare costs would be. And we then used that predictive model to estimate what the people in PACE, what their costs would have been if they had remained in fee-for-service.

DR. LAVE: So you didn't go into the MCBS and try to match people in the MCBS data to your PACE people and look at those costs. What you did was you predicted what the cost of the PACE people would have been under fee-for-service; is that correct?

MR. GRUENBERG: That we --

DR. LAVE: There's a difference because in one case you're actually looking at the costs of specific individuals. In the other case, you're looking at predicted costs.

MR. GRUENBERG: Right, we didn't really have the cost of -- any way of estimating the costs of specific individuals.

DR. LAVE: You could have taken people from the MCBS that looked like your PACE people and picked up their costs.

MR. GRUENBERG: I think that what we did was an efficient method of doing that.

DR. NEWHOUSE: I think you've got a few puzzled commissioners, but go on.

MR. GRUENBERG: Then I also wanted to discuss in the next slide, that what we could see over time was that people that looked like people from PACE, that their relative costs increased. They increased more rapidly than the Medicare population. And I'm not going to really spend time on the slides, because I only have a short amount of time.

But what you could see quite clearly from looking at data in the MCBS from 1992 through 1994 is that frail people got much more -- that their costs increased much more than did the average Medicare recipient. And a lot of that

was coming about because of the cost of home health services. That the cost of home health services increased dramatically overall but it increased even more dramatically for the frail.

So home health was being more and more focused on the chronically ill population. And for that reason, the costs of people who are like the people in PACE were like the nursing home level people in Social HMO. In fee-for-service these people were getting a higher and higher proportion of Medicare services over time.

DR. NEWHOUSE: Is the same method that you used for the previous slide?

MR. GRUENBERG: Yes, this actually took the data -- what we did was we created an imprint or a picture of the PACE population. We then transferred that to 1992, 1993 and 1994 MCBS data.

So the people who look the same in 1992, as time went on they got a higher and higher proportion of Medicare services. Medicare costs went to those people.

DR. NEWHOUSE: So if I understand what you did, let's just say you just used age and sex and obviously you

used more than that. But if you had people in PACE that were 70, 75 and 80, then you predicted costs based on the age distribution of the MCBS and then you predicted at age 70, 75 and 80? Is that the essence of what you did?

MR. GRUENBERG: I took all the health variables --

DR. NEWHOUSE: I understand. You took a lot more variables.

MR. GRUENBERG: I predicted the costs and then I took the model of predicting the costs in each year.

DR. NEWHOUSE: And you plugged in the variables for the PACE population?

MR. GRUENBERG: Yes.

Now, the third slide is actually the result of an analysis done by PACE where they took the actual data on the hospital discharge information for all -- this is actually real data. This was done by Helena Hempkin Greener in one of the PACE sites.

She took all of the data from the hospital discharges and found their diagnoses and then determined what would they have been paid under the PIP model. And they currently get 2.39 times the AAPCC and it was

estimated, on the basis of this analysis, that they would only have gotten 1.25 or slightly more than half.

The reason for this is that in PACE the hospital utilization is very low and therefore very few people are recognized to have diagnoses that are given recognition.

DR. NEWHOUSE: What would this have been under the AAPCC? Less than 1.25? The 2.39 just descends out of the sky and multiplies the AAPCC rate. So it would be one?

MR. GRUENBERG: Actually, this study was done before the most recent set of PIP, in the final version of PIP there is recognition of Medicaid status, and this was not included in this slide. But when Medicaid status is included, we believe that this will increase somewhat to about 1.6 or 1.7.

So there is some improvement in the ability of the PIP model to -- in paying PACE, but it still underestimates by about 30 percent compared to what it is currently.

Actually, this slide shows some real data from the -- I'm sorry, I wanted to show another slide that says table on top. I believe it got reversed.

Now this actually shows data from Massachusetts

from dually eligible Medicaid-Medicare recipients in Massachusetts 65 and over, and what this shows is -- this is claims data. We looked at individuals and based upon their claims we identified whether in the first month of the year if they were in an institution. That's the fourth row -- or if they are in a waivered program, they're nursing home certifiable. If they weren't in a waivered program but they were getting Medicaid long term care services in that first month we called them moderately impaired. And all other Medicaid recipients who didn't fit into any of those categories we're calling well.

Then the second column shows what their actual Medicare costs were for the year per capita, and the first column shows what the payment rate would have been under the HCC model which is the model that in the long run would be thought to be used.

What these data show is that the people who are severely impaired who are nursing home certifiable would have cost almost four times the AAPCC, and that there would be -- and they would have only been paid -- the last column shows the predicted ratio. It shows what percentage they

would have received.

DR. LAVE: Where do you get the four times? I don't see that.

MR. GRUENBERG: 3.83. And that they would have only been predicted to have cost two times, 2.06 times the AAPCC. In contrast, the people in institutions would have been predicted to cost 1.8 and they only cost 1.41.

At any rate, there is a systematic underestimate of the Medicare costs on the basis of diagnosis alone for people who require long term care services.

DR. NEWHOUSE: What's the rough distribution across these five rows?

DR. KEMPER: In terms of number?

DR. NEWHOUSE: Yes.

MR. GRUENBERG: How many people? Actually, about one-third of the population or -- between one-third and 40 percent are in institutions. Then among the community population there's only a few percent. I think 8 percent are either nursing home certifiable or moderately impaired. And the remainder --

DR. NEWHOUSE: The total of those is 8 percent

roughly?

MR. GRUENBERG: I don't remember whether it's 8 percent of the whole or 8 percent of the community, but it's something relatively small. In other words, the well population and the institutional population dominates.

DR. NEWHOUSE: So do you know roughly what the standard error is on the NHC group and your moderately impaired group?

MR. GRUENBERG: The standard error is in the third place. The numbers of people are in the thousands and the standard --

DR. NEWHOUSE: No. But if I'm looking at your 3.83, what's the confidence interval for that?

MR. GRUENBERG: The standard error is in the third place, it's 3.83 plus or minus .05.

DR. WILENSKY: Is the fact that the Medicare expenditures for the institutionalized is, the actual 1.4 versus 3.8 for the nursing home certifiable, saying something about what happens in the institutions or what happens keeping people out of the institutions? I mean, that's a rather large difference.

MR. GRUENBERG: Yes. We looked at that in another study using the data in the current beneficiary survey, and what we found was that there were two major differences in the people in institutions and the community. First of all, the people in the community received home health services, and that amounted to about .8 of the AAPCC. In other words, the people who were frail, who were NHC, in the community received home health services equivalent to about .8. And people in institutions aren't -- presumably they're getting the home health services from the nurses and the nursing home.

We also found that a very large portion, about 50 percent of the people who died in nursing homes were not hospitalized in the year of their death. Whereas, among the people that were nursing home certifiable in the community, almost 100 percent of them were hospitalized before they died. Actually that, in the national data set that really accounted for a very large part of the difference between the nursing home and the community.

DR. KEMPER: Lenny, is the nursing home cost itself, a fair amount of that would be paid for by Medicaid

or paid for privately rather than by Medicare; is that correct?

MR. GRUENBERG: No, this is all Medicare. This is only Medicare costs.

DR. KEMPER: So the people who are in institutions aren't covered by Medicaid?

MR. GRUENBERG: No, they're all covered by Medicaid.

DR. KEMPER: So the nursing costs are out of there because of -- by Medicaid and private payments?

DR. NEWHOUSE: Not necessarily.

DR. KEMPER: Well, some of it. Some of it's out of there.

DR. WILENSKY: I guess that really is a very -- that's a really key question, what the missing -- what the other piece of their expenditures are.

DR. KEMPER: But I don't think it's surprising because of that, both because of the political side of it --

DR. WILENSKY: There are two things. One, on the predicted they're quite close. In the actual, they're not close. So I guess the first thing is that difference.

DR. CURRERI: The hospitalization could account for that. If they all got hospitalized when they died, and the nursing home people died in the nursing, there would be a huge difference.

DR. WILENSKY: Just the issues about the cost involved of keeping people who are nursing home certifiable out of the nursing home versus keeping people in the nursing home. I mean, these are really large differences.

DR. KEMPER: But I think you have to think about the fact that not all the costs are here because of Medicaid.

DR. WILENSKY: That's what I meant. I agree.

MS. ROSENBLATT: Is this a multiplier to the old AAPCC that already includes an adjustment for institutionalized status?

MR. GRUENBERG: No, this is actually -- this is simply a ratio between the observed costs -- I mean, the second column is a ratio between the observed costs and the mean for the whole Massachusetts population in that year.

DR. LAVE: And the predicted is based on the DCGs or whatever?

MR. GRUENBERG: Yes.

MS. ROSENBLATT: No, I thought --

MR. GRUENBERG: On the HCC -- yes, on the DCGs.

MS. ROSENBLATT: And the HCC model was both inpatient and ambulatory care?

MR. GRUENBERG: Yes. Now the next is looking more broadly at functional level using the current beneficiary survey. What I did in this table is look at the entire elderly population in the community in five groups. The lowest group, geographically on the table, are people who have some need for help from another person in one or more ADLs. Then the next group are people that need help from another person in IADLs. Heavy housework was kept out as a separate item of IADL and is what I call the chore group. Then there's also another group of people who can do all their IADLs and ADLs without help but had some difficulty lifting a 10-pound object or walking two or three blocks, which we found to be significantly correlated with Medicare costs.

What this table shows is that there's quite a good correlation of Medicare costs with these broad functional

categories, where the unimpaired that correspond to nearly half, or 40 percent of the population, they have a cost ratio of only .57. Whereas, the home health group has a cost ratio of over two; people with ADL impairments.

Then the next slide shows that in 1992 and 1994 -- there's an awful lot of data here and I'm just going to highlight a small part of it. But it shows for these five groups, how well does the HCC model, the PIP model, and the AAPCC match what the actual Medicare costs are.

If we just look at, let's say the home health group which is of most concern of being the kind of people that are in the PACE program or that the services are directed in the social HMOs.

DR. LAVE: Excuse me, can you tell me what the PIP model is again?

MR. GRUENBERG: The PIP model is the inpatient, principle inpatient.

DR. LAVE: So the HCC uses the inpatient and the outpatient to classify patients?

DR. CURRERI: Right.

DR. LAVE: The PIP uses the inpatient.

MR. GRUENBERG: So. So if we look at the home health group, their cost -- starting in the first column, their cost ratio increased from 1992 to 1994 from 2.20 to 2.65. This is connected with what I mentioned in the earlier, somewhat questionable analysis of the PACE data. But what it shows is that there is really a systematic increase in the relative amount of resources that frail people are getting, and that as time --

DR. NEWHOUSE: Does this excludes decedents? This excludes the decedents, right?

MR. GRUENBERG: No, this actually includes everyone.

DR. NEWHOUSE: If you died, are you in the MCBS?

MR. GRUENBERG: It's the next year. In other words, there's a survey done at the end of one year and this looks at the cost over the full next year. And if someone died, their costs were counted for as large a part of the year as they were alive.

So first of all, the cost of people who are in the home health group were over two, and they increased somewhat. Then under the AAPCC those costs were

underestimated by more than 50 percent in 1994. That's the column all the way to the right; 54 percent in 1994 and 48 percent in 1992. But we found also that under the PIP and HCC model, they continue to be underestimated by anywhere between 25 percent and 45 percent.

In contrast, there appears to be quite a striking correlation with level of functional impairment. That the unimpaired group, who are people who are quite health, at least in functional terms, there's quite a significant overpayment. That continued under the AAPCC, and that continued under the diagnostic models as well.

I'm not going to spend much time, but the next slide also shows that as a function of the number of ADL impairments that the error increases -- the error in reimbursement -- first of all, the cost ratio increases with the number of ADL impairments. Also the error under the AAPCC and PIP, and the HCC model also increase with the number of ADL impairments.

DR. NEWHOUSE: This still is the MCBS?

MR. GRUENBERG: This is the MCBS.

DR. CURRERI: How do you handle in this data if

somebody is in zero, has a stroke in July and now has four ADL limitations? Do you do it per month or --

MR. GRUENBERG: No. Actually under -- we followed essentially the way it was going to be done under the PIP and the HCC model, where we look at them in one point in time and we're then following their costs over the next year. So it does include a certain number of people who's status changed during the year.

In fact, I did want to add a comment about, going back to the question about the nursing home. What we found in the study was that the people who are really costly in the nursing homes were the ones over their first six months of entry, and that isn't really being picked up. When we classify people at one point in time and look at them over the year, we're only picking up the long term people that are living in the nursing home, and we're not picking up the new admissions.

That's also a change and the current AAPCC actually is addressing that where people's status change when they enter a nursing home and the payment rate is changed. Whereas, under the new proposed method, that

wouldn't be recognized until the next year. I think that's one of the reasons why the nursing home cost looks so low, is that those people are people are being excluded.

The next table --

DR. LAVE: Excuse me, on the AAPCC stuff -- oh, that doesn't change. Sorry, go ahead.

MR. GRUENBERG: The next table shows, using the MCBS and using a model that fits how the social HMOs determine who's nursing home certifiable, we could predict which people in the MCBS were nursing home certifiable. We have a model to predict that. This is an attempt to look at what the payment rate would be for people that were in nursing home certifiable.

We found that there's an error of -- there continues to be an error of 50 percent under PIP and 37 percent under HCC for people that look like nursing home certifiable people. And that pretty much matches what we found -- if you don't like, to a certain extent there's a certain amount of smoke and mirrors of trying to create the nursing home certifiable people using data from one source and applying it to another involves some waving of hands.

But it's pretty much confirmed by the same findings regarding ADL impairments.

DR. ROSS: Could you just say something about why the mean error, the prediction for all persons on both of these last two tables is negative to the HCC model and to the PIP model?

MR. GRUENBERG: This only includes the community population, and it doesn't include the nursing home population. If we included the nursing home population -- and actually, the HCC model over-predicts the payments for the nursing home population to some extent, and that's why it comes out under 1.0.

That covers my points one and two. I wanted to just make some comments, or points three and four that I wanted to make.

That actually, the social HMO, as it was originally envisioned included a long term care benefit and a pharmacy benefit, and those are actually mandatory benefits that must be offered. And that if a social HMO was going to become part of a mainstream Medicare+Choices, even if the payment formula were accurate and reflected

disability level as well as diagnoses, there would still be a very big problem. Namely, social HMOs would have to charge premiums that would cover these extra services, they would be very attractive to people who needed those extra services and they would end up competing with low cost plans that didn't offer those benefits, and then that would lead to a spiral that I don't think that those programs could really exist.

I think that there were several -- that under the demonstration program status, the programs were able to survive through various inefficiencies in a system that were there. But I don't think that really provides a basis for a real permanent program.

Then the fourth point I want to make is --

DR. WILENSKY: Is that true even if you use the disability as a risk adjuster?

MR. GRUENBERG: Right. All that would do is give you a fair payment for Medicare's part. But then the extra services, which might cost $50 or $60 or $80 a month extra would have to be paid for somehow, and presumably that would be paid for out of premium.

DR. WILENSKY: But most people -- I mean, there's 10 percent that doesn't have anything. But 90 percent of the senior population has either private insurance or Medicaid to wraparound. So I understand the selection issue, but it strikes me that given the high number who have something that -- it's more a selection problem with regard to the 10 percent, or maybe the 20 or 30 percent that might not have pharmacy coverage. But it's not as much as --

DR. NEWHOUSE: I think it's the long term care benefit.

DR. KEMPER: But isn't it an additional benefit issue? Another way of dealing with it would be to relax the requirement that the social HMOs offer this additional benefit. They're required to have the drug benefit and so on.

DR. WILENSKY: Whether they have drug benefit is less the issue. It's whether they have a long term care benefit.

DR. KEMPER: But even the drug benefit is not --

DR. WILENSKY: That's true, they don't have --

DR. KEMPER: That's not a Medicare benefit yet.

DR. WILENSKY: Right.

MS. NEWPORT: And the long term care benefit isn't -- in some areas it's not long term care. It's a shorter care.

DR. WILENSKY: Yes, if they weren't required that would certainly take it -- they presumably would have it just like most of the other HMOs have it.

DR. LAVE: Then they wouldn't be any different from them.

DR. WILENSKY: Right.

DR. KEMPER: In other respects they're different, but not with respect to those benefits.

MR. GRUENBERG: In a sense, I think the new social HMOs are -- they do not have a well-defined -- they're not really responsible for long term care services. And I think that's because they recognized that they can't really --

DR. NEWHOUSE: How many new social HMOs are there?

MR. GRUENBERG: There's one in operation.

DR. LAVE: One social in operation?

MR. GRUENBERG: One new one.

I did want to make the last point. That actually the most serious problems in the payment formula are for the people with serious disabilities, the only maybe 7 or 8 percent of the population who have ADL problems. If you look at the R-squared, what you find is you don't really increase very much the explanatory power by adding in an ADL correction.

However, if you don't include it, what you then do is you would very severely underpay for that population. Although it's a small population, there are as many as 50 percent of us who will have some period in the last three or four years of our life where we have those limitations. And I think that it's quite serious that if the HMOs are underpaid for those people, they're not really going to be very interested in providing, in attracting them and in providing good care for them.

So I feel as if, while that's not really the purpose of this meeting, that these issues need to be addressed overall, and not just in the payment formula for the social HMO and PACE.

MR. POPE: I think I'm going to pick up a little

bit on Lenny's last point. The work I'm going to present, and I think I can be fairly brief because there's a lot of overlap between what Lenny presented and what I'm going to present, including using the same data. So I think our results are pretty much consistent, so I'll just try to hit some of the highlights here and pick up on this last point.

This research was really funded by HCFA, finished about a year ago. Was oriented towards risk adjustments for the general population, not specifically focusing on SHMO and PACE and EverCare and so forth. But part of it dealt with the issue of functional status which is relevant. I think it does have some relevance in that context. So let me just run through the overheads.

As I'm sure you're aware, the BBA requires health-based risk adjustment beginning in 2000. There are really two major types of risk adjusters that have been studied over time. One model is using diagnoses from claims and encounter data, and the other model is using health status surveys of beneficiaries.

So our research questions that we addressed in the study were, what is the predictive ability of each type of

model for individuals and groups? How do the models compare? Is a single model accurate for all types of beneficiaries? And I'm going to focus on the frail elderly results here because that's the topic of discussion, although we looked at a lot of other subgroups of beneficiaries as well. And what are the gains from a combined model incorporating both diagnoses and functional status?

As I mentioned, we used some of our data to what Lenny did, three years of the current Medicare beneficiary survey in the early '90s. Our sample include aged and disabled. It's a Medicare fee-for-service population. ESRD was really the only exclusion. The institutionalized beneficiaries are in here. The sample size is about 11,000 per year.

We did analyze prospective models, as Lenny described, where the survey or the diagnoses are coming from a base year or a prior period in time and we're predicting expenditures in the next year. We had an estimation sample and then the results I'm going to report are from the validation sample in another pair of years.

We looked at quite a range of risk adjustment models ranging from demographic, which you can think of as the current AAPCC-like models, survey health status. We looked at a number of different variables available on the MCBS including functional status, counts of difficulties, and activities of daily living. Those include bathing, dressing oneself, walking, eating, and so forth.

We also looked at general health status; people rating their health as excellent, very good, good, fair, or poor. Self-reported chronic conditions; has the doctor ever told you you have cancer, heart disease, so forth. We tried to simulate an SF-36-like model, because that's a widely used health status assessment instrument. So we wanted to try to get some idea of what that might look like. Then we put some of these different variables together in what we called a comprehensive survey model.

In terms of claims diagnoses, we used the same two models that Lenny's been talking about, the PIP-DCG, which is the model that HCFA is proposing to start using for Medicare risk adjustment beginning next year -- and that's based on principal inpatient diagnoses only -- and then the

HCC variant of DCGs, which include physician and other ambulatory diagnoses as well as the hospital diagnoses.

Then we did some combined models throwing the claims diagnoses and the survey measures together, and then finally, prior year expenditures. So it was quite a laundry list.

We focused on two measures of model performance. One is ability of the models to predict expenditure differences among individual Medicare beneficiaries, the R-squared statistic, and the second, the predicted ratio type of statistic that Lenny was using where you look at the mean predicted cost compared to the mean actual cost, and if that's one it means you're predicting accurately.

To take the R-squared results or explaining the variation among individuals first, this slide shows a lot of numbers, basically kind of ranked from least explanatory to most explanatory, the higher numbers being better. The demographic models are basically at the top of the chart. Then there are a bunch of survey health status models which are including self-reported health status, chronic conditions, the excellent, good, fair, poor types of

measures.

Then down at the bottom in the most explanatory were the models using claim diagnoses, and the combined models where we took the claims diagnoses and the survey measures and put them together.

DR. CURRERI: Could you tell me what these -- what are we measuring with these numbers? I mean, R-squared values I'm used to being between zero and one. So this is not R-squared.

DR. NEWHOUSE: This is R-squared times 100.

MR. POPE: Yes.

DR. KEMPER: It's percent.

MR. POPE: These are like .1 on that, less than .1.

DR. ROWE: This is percent of the variance that's attributable to each of those.

DR. CURRERI: So this really would be an R-squared value going from .07 to .79; is that right?

MR. POPE: Correct.

DR. LAVE: To .79 or .079?

MR. POPE: .079.

DR. LAVE: That's a big difference.

DR. ROWE: And age has no effect because there wasn't enough variance, variability in age in the sample?

DR. LAVE: No.

DR. NEWHOUSE: No, it just doesn't explain much.

DR. LAVE: It doesn't explain anything.

DR. ROWE: There was a fair amount of variability of ages in the individuals?

MR. POPE: Yes, the whole Medicare population, age and disabled.

DR. WILENSKY: Just doesn't do much.

DR. ROWE: That's fine. I'm just understanding whether it really didn't do anything or whether this was constrained by the data set.

DR. NEWHOUSE: No, this is a longstanding problem.

MR. POPE: There are two other points I'd like to make about this overhead. One is if you add the survey measures to the claims diagnoses, which would be the PIP-DCG and survey, and DCG-HCC and survey compared to the PIP-DCG and DCG-HCC without the survey variables, that there is some increment and some additional explanatory power provided by

the survey measures, in particular for the PIP model which doesn't include ambulatory diagnoses, although the increment isn't enormous. But there is some.

The other point is that the prior use or claims-type models, including the prior use model and the claims diagnostic models tend to do much better than the survey measures for the disabled, but that the gap among the aged beneficiaries is quite a bit less, although the claims models still tend to do somewhat better.

MR. MacBAIN: Just a quick question on this. These are based on a random sample. When these approaches are used to pay a managed care program it's applied to a self-selected sample. Do you have a sense of how great a difference you find in the predictive value when you've got a self-selected sample?

MR. POPE: Not a great deal. I think we currently have a project for HCFA where we're looking at calculating these type of scores for particular managed care plans, and HCFA has these scores for a lot of managed care plans that I haven't seen. So I assume people at HCFA are looking at some of those type of issues, but I don't know, or the

ongoing work I can't really talk about in detail at this point.

MR. MacBAIN: My concern would be particularly in the context of a program like PACE where you're dealing with a very small enrollment to begin with, that the self-selection factors may overwhelm all of this stuff.

MR. POPE: The hope is that you can predict accurately even for those groups with the risk adjusters, although as Lenny has indicated, that's questionable whether you can with these models, especially without the functional status.

DR. NEWHOUSE: Did you interact with anything where you estimated these specifically for the aged and then separately for the disabled?

MR. POPE: These results are based on a combined estimation --

DR. NEWHOUSE: I know that. So did you results for non-combined?

MR. POPE: No. I mean, we did look at them separately and I think there are some differences in the parameters, and that would be a good thing to follow up on.

But no, these are not and I don't have any non-combined results.

The next slide is on predictive ratios where, again, one indicates you're doing well and deviations from one, either above one or below one are bad. Above one is over-prediction and below one is under-prediction. I focused in on the institutionalized population and the functional status, and also the elderly helped with three or more activities of daily living.

I think the results, if you look here, the asterisks basically indicates statistically significantly different from one, since we're dealing with a relatively small sample here. If you just sort of focus on the stars you can see that the claims diagnostic models, the PIP-DCG and the HCC models don't predict accurately across the spectrum of functional status. That they under-predict for the more functionally impaired and over-predict for the less functionally impaired, with the PIP-DCG being worse in that regard that the HCC.

So in other words, when you add ambulatory diagnoses you do improve the prediction across the range of

functional status, but you still under-predict for the most impaired and over-predict for the unimpaired.

The magnitude of the under or over-predictions is fairly substantial, as I think Lenny has found, especially for the inpatient based PIP-DCG model. It's under-predicting around 30 percent of Medicare expenditures for the most impaired groups and over-predicting by 30 percent for the unimpaired. So I think our findings are consistent with Lenny's there.

The other three columns include survey variable, and in particular actually include functional status, the same scale of functional status. And not too surprisingly, those models none of those predictive ratios are different from one; i.e., the prediction seems to be much more accurate including those variables. Sort of indicating, if you want to get predictions right for these functional status groups that you need to include functional status measures.

DR. WILENSKY: Have you tried to think about any way to quantify how much bias you might get in reporting -- the impact of bias in reporting, or the equivalent of DRG

creep, if you were to actually make payment based on reporting of functional status or of IADLs?

MR. POPE: No.

DR. WILENSKY: To try to estimate -- I don't know whether -- to try to think about how much impact that could have on the ability to predict expenditures. I mean, it's easy to imagine pulling this off for a year or two. But it's kind of hard to imagine having this be a long term definer, just because it seems like it's too subject to manipulation.

MR. GRUENBERG: That's dependent upon how it's implemented. I think the method that's thought of for the social HMO two is to use a self-report, and people don't seem to be very happy about that. But it may be that what you really need to think about is the ADLs of other diagnosis where perhaps you use a survey as a triaging method to get people into some evaluation, and that would then perhaps become a part of their permanent record.

MR. POPE: You could use some kind of clinical assessment. I would actually find the functional status to be among the more verifiable, potentially, of the survey

type measures. Because another one is the, how are you feeling, excellent, good, fair, poor? I don't know how you would audit that. Whereas functional status, at least theoretically whether someone could bathe themselves seems a little more objective than --

DR. ROSS: But there's a cliff here between one and two, and three and four that drops payers by about 10 percent.

DR. KEMPER: I think this is a really important point because I think we need to change the mindset a little bit of thinking of ADLs as a survey measure as opposed to a clinical measure. Because when Sid Katz developed the ADLs he developed me -- correct me, Jack -- as a clinical measure.

DR. NEWHOUSE: So were DRGs for quality of care.

DR. KEMPER: Right. So I think both in terms of thinking about feasibility of whether it requires a survey to implement it, and also just in terms of the way we think about it, one can think of them as clinical. Now I don't --

DR. NEWHOUSE: So how would you implement it?

DR. KEMPER: I think that's a big question. But

ADLs are already part of some of the fee-for-service side, or will be as we implement OASIS and the --

DR. NEWHOUSE: We haven't implemented it yet.

DR. KEMPER: Right. But I mean, as that goes forward there would be some of those available, and they are available in all these programs.

DR. WILENSKY: I'm really asking the question because it clearly has a better predictive power than other strategies. So the question is, if you start seriously thinking about that, how much of an issue does this become.

DR. KEMPER: It's critical one.

MR. POPE: One other comment on that is -- and it's not an original point with me, but these type of measures are also being used for health outcomes assessment. And while plans might have an incentive to report their beneficiaries as being sicker for the point of view of getting more payments through risk adjustment, from the point of view of trying to look like they're improving the health of their members over time, they might have an incentive to report their members as improving in health. So perhaps we just saw offset each other.

DR. WILENSKY: You don't really believe that.

[Laughter.]

MR. POPE: If I could just stick on this for one more second.

DR. ROWE: That would be wonderful. You know, if people were purchasing these services based on whether -- not the cost, but whether they really felt that there was going to be an improvement in their health status from them, I think that would be wonderful.

MR. POPE: There is a HEDIS measure based on Health of Seniors which, you know, SF-36 --

DR. ROWE: I know, but my statement still stands. If people were purchasing these things based on what they thought the HEDIS measures changes were, that would be great.

MR. POPE: I did want to just point out on this overhead, in the institutionalized line you'll notice that actually the survey measures tend to over-predict for the institutionalized. I think Lenny had a more detailed analysis of this, but I'm presuming this is resulting because the community impaired people are more expensive

than the institutionalized, to Medicare, to impaired people. So therefore, you get the over-prediction for the institutionalized. There is kind of an average and presumably an under-prediction for the community --

MR. MacBAIN: I'd ask you to speculate a little. One of the things that Jack points out periodically is the pseudo-miracle cure inherent in either the HCC or the PIP-DCG approach.

DR. LAVE: Is the what?

MR. MacBAIN: The pseudo-miracle cure where on January 1st of the following year somebody becomes perfectly healthy because the data disappears, the lack of persistence in the diagnostic data from one year to the next. The ADL survey may be making up for that in the sense that you're measuring more persistent characteristics.

Do you have a sense of what happens if you were to do a longitudinal study of a cohort of patients over say four or five years, what the predictive value would be of the survey versus just the straight claim-based approach?

DR. ROWE: Can I add something to your question here because I think this is very important? There's a

distinction. Just like Gail pointed out to me the difference -- I was comparing one thing to another and it was apples and oranges.

With certain diagnoses, such as quadriplegia, they don't go away. In the beginning with ADLs and functional status, a lot of people working in the field and a lot of the literature really suggested that there was a relentless momentum toward increased frailty and a hierarchy of adding additional ADLs as you got worse and worse.

But further study has really shown that people move in and out of disability. They move in and out of health and frailty. And that people do drop ADLs. You know, if they have a couple ADLs out, then they do get some proportionate of them, in fact maybe a significant proportion of them get better the next year with treatment, or the natural history of their illness. So there is a distinction between the impact on the data sets.

But what that caveat, we'd be interested in what you know about this and what you have about it.

MR. POPE: I think the studies -- I know I saw one recently from the Netherlands that shows if you add more

years of diagnostic data, say from claims, that that improves your prediction and it tends to reduce the incremental explanatory power of functional status, although functional status still has some -- I mean, one other comment is that it's sometimes claimed or often claimed that functional status through surveys can pick up sort of unmet need in the sense of people that don't get across the threshold.

MR. MacBAIN: But the issue here is not adding more years of diagnostic data, it's adding more years of claims data. So the diagnoses picked up from claims may give you -- you may get more data and less information just because of the way claims are coded.

MR. POPE: So you're particularly interested in more years of functional status data?

MR. MacBAIN: Yes, just a question of what happens if you take this study and extend it over a period of three years using the same cohort of patients.

MR. POPE: That would be an interesting thing to do, but I --

MR. MacBAIN: That's what an HMO does when they

enroll people, and they have to live with that. So it would be interesting to sample it closer to a real world model when you're looking at results not only in -- you're trying to simulate the year following enrollment here. But the question is, what happens in the second and third year for that cohort.

MR. POPE: For expenditures and some particular --

MR. MacBAIN: Yes, versus the predictive value of either PIP-DCG, HCC or other of those plus an ADL survey.

MR. POPE: I think there has been some work done on that for the DCG-type models but I can't quote it off the top of my head. I'm sure there's regression to the mean and the explanatory power deteriorates over time.

The next slide just briefly, this actually has -- it's more recent and just updates to the PIP-DCG model that HCFA's actually proposing to implement. What I particularly wanted to look at here was just the difference between the two columns where you add in the Medicaid and what HCFA calls the originally disabled factor, which Lenny also touched on briefly.

If you look at the institutionalized, actually we

add in those two factors, the PIP-DCG plus those factors in the institutionalized as an entire group seems to predict pretty accurately. And there is improvement in the prediction for the functional status groups, but there's still substantial under-prediction. So those extra demographic factors help but they don't solve the problem.

In terms of conclusions, from our study our conclusion was that the claims diagnoses models have the greatest overall predictive power -- this is for the general Medicare population -- but they predict inaccurately across some beneficiary subgroups dimensions of interest, such as functional status. And adding these two demographic factors, originally disabled and Medicaid -- and of course, if you can add in ambulatory diagnoses eventually to the inpatient diagnoses, it improves the predictions across the functional status groups, but it doesn't look like it's going to get all the way there and you're still going to have this inaccurate prediction across the functional status groups.

If I can just run just real quickly on the last two overheads.

DR. ROWE: How much does -- adding ambulatory does improve it?

MR. POPE: Yes. We'd have to --

DR. ROWE: Is that a belief or that based on --

MR. POPE: No, that's shown in the result a few overheads back where --

DR. ROWE: Okay, go ahead.

DR. WILENSKY: Can you try to do this quickly because we need to get to our recommendations?

MR. POPE: Okay. Let me just mention that in terms of sources of data, if one was interested for Medicare in adding in functional status measures, there is the health outcomes survey, formerly known as the Health of Seniors survey, which does have a sample of 1,000 beneficiaries per Medicare health plan and which does include functional status measures.

DR. NEWHOUSE: What percentage of 1,000 would be expected to be zero, or a random 1,000?

MR. POPE: Zero ADLs?

DR. NEWHOUSE: Zero ADLs.

MR. POPE: You'd have about 600 respondents, and

then of those, maybe --

DR. LAVE: Lenny only had 8 percent on the Medicaid population.

MR. POPE: It's probably pretty high.

MR. GRUENBERG: Depends on how you measure it.

MR. POPE: I could look it up in my report. I don't know off the --

DR. NEWHOUSE: They disproportionately don't have the very old.

DR. LAVE: Right. So it's going to be -- they have 8 percent on the dual Medicaid.

DR. NEWHOUSE: It's a very small sample.

DR. LAVE: So I would guess it would be about 3 percent.

MR. POPE: Then there are some other sources that have been mentioned, but they're population-based at this point, more based on nursing facility assessments.

I guess I can end at that point.

MR. GRUENBERG: Can I just make one brief comment?

DR. WILENSKY: Sure.

MR. GRUENBERG: I think one of the problems I

think is that in -- for Medicare we don't know who is in a nursing home and since the costs -- the people who are ADL impaired, half of them are in a nursing home and half are in the community. And the more you get the higher impairments, the more are in nursing homes. So a certain part of this problem is really not a fundamental problem having to do with disability, but it's really that because the data set doesn't specify who's in the nursing home you're, in a sense, for certain types of diagnosis, taking an average of the cost of the two.

So I think that in fact if other work could be done with some of the data where there are -- we know whether the people are in nursing homes or not, it might be that there would be a very, very substantial improvement. I don't think that would answer the whole question.

DR. LAVE: If you come to the chart that's called predictive ratios for risk adjustment models, can you tell us any idea at all -- this is related to the 1,000 people -- what the distribution, what percent of the Medicare beneficiaries fall into each of these groups?

MR. POPE: Into each of these groups on this

table?

DR. LAVE: Right?

MR. POPE: Not off the top of my head, but I can look it up.

DR. LAVE: Could you look it up. It would be very interesting, because that will give us some sort of sense about the survey problems.

DR. NEWHOUSE: I guess non-response is the issue rather than sampling error. Standard errors would be on the order of --

DR. LAVE: They're both a real problem.

DR. NEWHOUSE: Sampling errors would be on the order of one-tenth -- one sigma is about one-tenth of a percentage point, or 3 percent on a sample of 1,000.

DR. KEMPER: I was going on to discussion, so if there are other questions --

DR. WILENSKY: Are there any other questions just on the data?

DR. LAVE: Very interesting.

DR. WILENSKY: Now I want to go to the discussion, and then go -- Sarah, I don't know whether you want us to

use the material to go through the recommendations, or Tim, or whether you just want us to go --

But Peter, why don't you go ahead on discussion?

DR. KEMPER: I think this is very valuable work and I think it obviously, to me anyway has a very important implication for the general risk adjustment, which was not the topic of today. But the notion that institutional status and ADLs might be very important seems to me something that ought to go in the Commission's risk adjustment work in general because the frail elderly are a vulnerable group that are going to have underpayments if -- at least based on these numbers.

Turning to the topic of the PACE and social HMO and other programs, I think this is a very important issue beyond just these programs, because these are examples of the kinds of innovations I think we'd like to encourage in Medicare. And I think it's very important in what we do here that we'll be setting a precedent for other kinds of innovations.

In that regard, I think it's very important to establish the principle of tying the payment to the patient

rather than to the type of treatment or the type of program that they're in as a general principle that we're shooting for. And the reason is that that means that other kinds of health plans and so on can also innovate because they will have the payment necessary to cover the services. So I think that's an important principle to establish.

As a practical matter, we may not be able to get there for these programs now because the technology isn't there and they clearly have higher costs because of the serious level of disability. So there's a short run or an intermediate run problem in getting to that general principle. But I think it's important in the materials and in the way we make recommendations to establish that principle.

The second thing that -- I guess we talked before about the fact that using disability doesn't mean that we're using a survey approach to introducing it. That it is a clinical measure. It can be thought of in records and certainly in these kinds of programs. So I guess the question is, is the ADL creep that's a big issue, and the feasibility of getting the measures. But I think that's

something that can be explored.

I guess the third thing which is more a technical point, but I think the addendum in, Lenny, your materials are important. And in that addendum -- I had not understand that HCFA included welfare status, Medicaid status, and whether somebody was originally in the disability program as part of the risk adjustment. But that just means all our work needs to compare to models that include that. And since they do seem to predict better, especially for these groups, it's something we need to pay attention to.

DR. WILENSKY: Any other --

MS. NEWPORT: I guess echoing what Peter said and maybe amplifying on it is, the basic question here, it seems two things are happening. One is that we have programs in place now with somewhat different outcomes in terms of what we thought we were testing. These are demonstrations. And I'm speaking mostly of the social HMOs. I think PACE programs are distinct and different some critical aspects. So questions on payment and risk adjusting for these special classes.

But also somehow we have to make it very clear in

our comments and recommendations that the difference between sustaining something for a short time and then whether or not we go forward and pay in the general community appropriately for these conditions, we need to bridge that gap. These were demonstrations to test payment methodologies to make sure that there's accurate payment for these conditions.

So at this point that's not being exported. So when are we going to do that and how do we do that? I think that's a really critical question, not only for existing entities, but then what should Medicare really be paying for these services? So I think we slide around that a lot because the SHMOs have been around for so long we just think that's all there are going to be. How do we make and export the benefits of those tests going forward?

Some of that relates then to how do we pay them in the next couple of years under the risk adjusted program? And understand that for the original generation of SHMOs, they were paid 100 percent of the AAPCC for those enrollees -- that subset of their enrollment that was nursing home certifiable. I think that that brings to my mind the

question is for those first generation of social HMOs, is only the portion that is nursing home certifiable going to be subject then to a special risk adjustment or not?

I'm looking at what we're talking about in terms of the impact on these programs of a delay of risk adjuster for one year for just the nursing home certifiable or not. So that's a technical issue.

Anyway, I think what we need to establish here at some point is the value of these payment refinements and go forward; is that not true?

MR. GRUENBERG: The social HMOs are paid 100 percent of the AAPCC, and the AAPCC is figured a little bit differently for people that are -- there's a correction for people that are NHC, and other people --

MS. NEWPORT: But that's what I'm trying to say. That's what I was trying to say, that there is a correction for that class of enrollment. Either way there is a distinction in payment that is different in the social HMOs than it would be in a regular HMO, if you will.

DR. KEMPER: Is it correct that if you were nursing home certifiable but not in a nursing home that you

got paid as if you were in an institution?

MR. GRUENBERG: No. Initially that was how it was done, but now the rate is higher. But also, the other people are paid less. In other words, the HMO -- it's a zero sum game. It isn't that there is an extra subsidy for the people that are NHC. But the people who are in the community who are not NHC are paid less than the social HMO.

MS. THOMAS: Starting at 100 percent.

MR. GRUENBERG: The average is 100 percent instead of 90 percent.

DR. KEMPER: But at the patient level that distinction is very important.

MS. NEWPORT: We have changes in payment that will have to drive a more refined analysis of what we recommend here today or in the future, and I think that we have to understand that very precisely in terms of the impact.

Then my concern has always been, we have studied, at least in the social HMO program, more than a generation of care being given. And what does that show us? And what do we need to recommend that should be exported to the general community?

We seem in one way -- I don't want to have our report emphasize risk adjustment wither thou ADLs or whatever, but what we are really recommending in terms of taking the benefits that have been studied by this program and need to be exported, and what shouldn't be. I think it's important, let's cut to the chase and figure out what we should be doing for the general population.

So there are problems with this small group of beneficiaries that are covered by this and continuing with these entities or not, and I think we need to understand what the impact is going forward.

MS. THOMAS: Let me just clarify that PACE is not any longer a demonstration, so it's a little bit of a different set of questions.

MS. NEWPORT: And at one point I did make that distinction. I'm trying to be as focused in my remarks as I'm trying to claim we should be on this.

MS. ROSENBLATT: I think these studies confirm some studies that were done by the Society of Actuaries a couple of years ago that said if you had non-random groups, then the existing methods like the PIP-DCG or the HCC were

going to under-predict those with high expenditures and probably over-predict those with low expenditures. So it's nice that we have two studies that are confirming each other.

A second point I want to make is that I really worry about data availability, which I think was touched on by some of the questions and comments we were making earlier, and the administrative cost of modifying the existing PIP-DCG model, or the HCC model, or whatever model. Adding survey data, adding an ADL indicator, all of that is going to cause additional cost of using a risk adjustment.

Then I think Gail touched on the issues of the gaming factor. So I would just caution the Commission that making any sort of recommendation to add survey data or add ADL indicators should not be made lightly.

I guess I have a question, because I don't know too much about SHMOs and PACE. What is HCFA proposing as the 1/1/2000 payment? I feel that --

DR. WILENSKY: It's in the recommendations. Why don't we wait until then? If you want to do the short answer, that's fine. But as part of whether we go with the

HCFA recommendation is part of our recommendations set, which I'd like to turn to.

MS. ROSENBLATT: Okay.

DR. WILENSKY: Tim?

MR. GREENE: In a sense, the discussion so far has addressed --

DR. WILENSKY: Right, it's just leading up to --

MR. GREENE: -- some of the things that we'll be otherwise discussing in here. I'll try and go through them quickly and, as I say, the discussion, your discussion has addressed many of the things that you'd otherwise raise now.

The Commission faces a number of basic choices before we even turn to specific recommendations. I'll just go through them quickly. One would be whether to immediately apply the Medicare+Choice risk adjusters; that is, the PIP-DCGs to these specialized plans.

Second, whether to continue to exclude them and pay under the old, that is the existing, methods.

Third, whether to develop improvements to the risk adjustment methods and apply them only to the specialized plans like the SHMOs and such.

And fourth, whether to develop risk adjustment, improve risk adjustment methods and apply them to frail elderly wherever they are in managed care. Should the payment follow the person in this case?

First issue is, should we apply Medicare+Choice risk adjustment to specialized plans. Here HCFA has temporarily postponed the application of the Medicare+Choice adjusters, PIP-DCGs, and will continue paying specialized plans with the current system in the year 2000. That's the answer --

MS. ROSENBLATT: Can I just get a clarification on that? Because right now SHMO is getting 100 percent of the AAPCC.

MR. GREENE: 100 percent of the modified, right. Of the modified Medicare+Choice.

MS. THOMAS: It's the base rate.

MR. GREENE: It's the base rate.

MS. ROSENBLATT: Without the institutional status then. So it's 100 percent of the new base rate that doesn't include an institutional status indicator; is that a fair way of saying it?

MR. GREENE: Right, reflecting the modified AAPCC factors. The SHMO is currently being paid to reflect the NHC factor.

MR. GRUENBERG: My understanding is they're going to continue to get the current payment method, which is the AAPCC, which has been adjusted to include a special NHC column.

MS. THOMAS: It's a little confusing to call it the AAPCC because it's really -- they're getting the Medicare+Choice case rate times 100 over 95. That's their base rate.

MR. GREENE: But also NHC modification.

MS. THOMAS: Right.

MS. NEWPORT: So it's been adjusted --

MS. THOMAS: They haven't got a recalculated AAPCC. They're moved to the new methodology as their base rate.

MR. GRUENBERG: Right, but there's still the AAPCC matrix.

MS. THOMAS: But the adjusters to the old AAPCC are still in place.

MR. GRUENBERG: Yes.

DR. LAVE: I have a question. What I don't know is whether we should be thinking about -- first of all, I'd like to say, I like Peter's suggestion and we may want to think about that up front, but that's a long range conclusion.

I don't know whether we should think about SHMOs and PACE programs differently. I don't know enough about them. And let me tell you what my concern is.

I don't know whether I should be more concerned about PACE programs and not much concerned about SHMOs or whether I should be concerned about PACE and SHMOs.

We know that the PACE programs are, in fact, designed specifically for extraordinarily risky patients. I mean, they have a very, very targeted patient population which, by definition and entry criteria, is supposed to be very frail. And so for that population, it is very much an at-risk population.

I don't know how much sicker the SHMO population is from a -- I mean, I don't know whether or not the SHMO population has been identified and targeted to the same

sense, or whether or not it was a different way to think about delivery system.

I've actually read some of the reports from this. I don't know whether or not I should really think of SHMOs as HMOs with added benefits, in which case the problem really is why do we do the SHMO group, because they can get the added benefits through the HMOs?

So I think if we're going to make definitions on SHMOs and the PACE programs, which are really more targeted, I'd like to have some sense ahead of time about how targeted the SHMOs are relative to PACE and EverCare.

MR. GREENE: As originally designed, they're explicitly non-targeted. There was an explicit effort to avoid selection by including a lot of non-frail, non-impaired people.

DR. LAVE: That's what I thought.

MR. GREENE: Secondly, some of the work we did and presented in November on mortality rates and so on suggested there's less of a difference between the standard HMO on the one hand and the SHMO populations on the other. In fact, a lot of movement back and forth between --

DR. LAVE: If that's true, then I think we should think differently about the nature of our recommendations towards the PACE and the SHMOs and that we may want to focus our recommendations primarily on the PACE-type programs, which have been specifically designed for a very at-risk population. And then if, in fact, we want to make changes in recommendations, that we may also want to make recommendations that may, in fact, worry about the gaming problems, at least in the short run, which may have to do with some sort of audit on the degrees of frailty of the enrolled population.

I'm just concerned about, given what I know about SHMOs, why we really want to hold them up as differently from HMOs who decide to go ahead and present augmented benefits?

MR. GREENE: As we work through the recommendations, there's sort of directions you could move given that orientation or other directions. For example, the question is should you postpone application of DCGs? You may lean one way or another, depending on how close you consider SHMOs to the standard HMO?

DR. NEWHOUSE: Do we know what entry is for PACE and SHMO? I mean, we had a provision for up to 20 new PACE programs a year.

MS. THOMAS: There are 21 right now.

DR. NEWHOUSE: 21 new ones?

MS. THOMAS: 21 total.

DR. NEWHOUSE: I know, but the BBA said you could add up to 20 a year. Are there any new ones?

DR. ROWE: Yes, there were 12 last year. Last time we did this there were 12 and now there are 21.

DR. KEMPER: Can I come back to this issue of frailty of the Social HMO population? This is a question of facts. I don't know whether anybody, Valerie, could just clarify the question of fact? Would that be appropriate?

MS. WILBUR: The number of ADL-impaired people in the community at large is about 5.3 percent. Within the Social HMOs, the average is about 12.2 percent but it ranges across the sites from about 10 percent to 20 percent. So the Social HMOs do have a significant number of ADL-impaired population relative to a traditional HMO.

I don't know if you took a standard M+C plan, what

the proportion of ADL-impaired would be relative to the average Medicare community population. Lenny, do you know the answer to that?

MR. GRUENBERG: No, in the evaluations of TEFRA, the mathematic evaluation, it was found that the prevalence of functional impairment was lower than in the community.

MS. NEWPORT: But the marketing, I think some of that is just distinct in terms of the marketing activity of the Social HMOs in their communities, too. I mean, that's driven by how they characterize their benefits.

DR. KEMPER: So it's not quite as simple, Judy, as you suggest, of treating them just like a standard HMO population, but they're probably less disabled than the PACE.

DR. WILENSKY: Why don't we try to answer this as we go through each of the recommendations because in some of them we may decide to go one way and treat the three together. And in some of the things we may decide to limit the recommendation to the sicker, to PACE and EverCare and not SHMOs. Whatever, but I think we don't need to necessarily make a distinction up front of how we want to do

this.

DR. KEMPER: Right. But am I correct that the bigger difference is really the fact that the Social HMO has additional benefits that are paid for by Medicare, the drug and benefits?

DR. NEWHOUSE: When you say are paid for by Medicare, you mean the extra five percentage points?

DR. KEMPER: Out of this --

DR. ROWE: That's used because that's -- the rationale behind that is that in order to qualify for that payment you have to have these certain additional services.

MS. THOMAS: Maybe we can just take EverCare out of the equation all together, because what the finding is that PIP-DCGs do a pretty good job of predicting costs for nursing home eligible people. So we may want to think okay, the current system would probably do a pretty good job for EverCare.

MR. GRUENBERG: I don't think that's --

MS. THOMAS: It depends on --

MR. GRUENBERG: The problem is the current system, when someone enters a nursing home, the rate is booted up.

And those are the very expensive people.

The new system, you set the rate for a year. So here's somebody, a healthy person has a stroke and goes into a nursing home. And then the rate won't be changed until next year. By that time the person may be dead. So the EverCare program has to take care of that.

DR. WILENSKY: You can't do that.

MR. GRUENBERG: So you couldn't have an EverCare program under the new system.

DR. WILENSKY: Actually, when I testified for the Finance Committee, that point was raised. Connie Mack was there, specifically raising that.

Recommendation one, which is on page three.

MR. GREENE: We restructured here, it differs slightly here from the recommendation numbering order in the mailing materials.

DR. LAVE: I'm not sure why.

DR. WILENSKY: However you want to do it. I'm just going through what was in my report.

DR. NEWHOUSE: But these are mutually exclusive alternatives, I think. That's our problem.

DR. WILENSKY: Do you want to use this as the structure?

MR. GREENE: I'd like to use this as the structure. We can go through them quickly, and then come back. So the question is here, whether to support HCFA in the direction it's going, postponing PIP-DCGs or not.

DR. LAVE: See, that's why I was -- from what I've heard today, I would support postponing risk adjustment for PACE programs. But I'm not sure I would postpone them for SHMOs and EverCare. That's why I --

DR. ROWE: Why don't we just have a -- I've got some plans for Saturday evening. Why don't we just go through these and have PACE, SHMO or whatever you want, and we can decide how we feel about PACE on each of these, SHMO on each of these?

DR. LAVE: That's good.

MR. GREENE: Postpone here means a one year postponement.

MS. NEWPORT: This is the one-year postponement?

MR. GREENE: Yes, this is a one-year postponement. You could, of course, recommend anything you want.

MS. NEWPORT: Then the question is, in the second year, are they going to apply the 10 percent blend or the 30 percent blend?

MR. GREENE: They haven't announced any plan, any third plan.

DR. CURRERI: And we have a third option here and that's indefinite.

MR. GREENE: You can recommend any variant you want but the basic question is do you endorse the HCFA one-year proposal of postponement or not? We can come back to that, if you want.

Then the second question is should you improve claims-based risk adjusters to apply to these plans? That is, do you want to refine PIP-DCG or something like that? If you decide not to postpone, do you want to work with PIP-DCGs or do you want to use --

DR. LAVE: But there's none available. And why would we do it only for these plans and not for everybody?

DR. KEMPER: I guess what I would --

DR. ROWE: This is kind of a clinically oriented comment. If I understand the PACE program, since they work,

the ones I've seen, the idea is to keep patients out of the hospital. That's one of the ideas.

If the idea is to keep patients out of the hospital then relying on the inpatient diagnoses seems not to make that much sense, as the patient is in the program a longer period of time. Which is maybe why ambulatory diagnoses improve the predictability or the amount of the variance which is attributable to these sets.

DR. NEWHOUSE: That raises the question, ambulatory data are off-the-table for the main line program. But for these programs, they may not --

DR. CURRERI: I understand. Ambulatory data are off the table in the main line program but that was not a program designed to keep people out of the hospital necessarily.

DR. NEWHOUSE: Some plans would argue with that.

DR. ROWE: I wish that they would be telling the truth.

DR. NEWHOUSE: Be that as it may, the issue is do we have any data on whether these plans could handle outpatient data? Whether they could --

DR. CURRERI: Because that's a problem with the general plan.

DR. NEWHOUSE: But that doesn't necessarily mean it's a problem with this product.

DR. ROWE: But if we have a program which is designed to keep people out of the hospital and then relying on inpatient --

DR. NEWHOUSE: No, no, no. I'm saying can we use outpatient data?

DR. LAVE: The issue is the feasibility of doing it.

DR. ROWE: If there's ever --

DR. NEWHOUSE: Why not? We couldn't do it in the regular program, so can we do it here?

DR. ROWE: Because this group is dealt with very differently. This is a group in which we really are --

DR. NEWHOUSE: Jack, this is a feasibility question, not a desirability question.

MR. GREENE: I think they're on the same schedule for data collection as regular programs. Is there anything new, other than the standard Medicare+Choice --

DR. NEWHOUSE: Do they have encounter data? We're not talking about huge numbers of providers here.

MR. GRUENBERG: The Social HMOs don't have.

DR. NEWHOUSE: How about the PACE programs?

MS. THOMAS: I think -- unfortunately, Chris Van Reeman was here and she had to leave. I think she has told me that they would be happy to provide ambulatory data.

MS. ROSENBLATT: But could HCFA accept --

DR. WILENSKY: We do not have to finalize a recommendation today. We'll have another month. So to the extent we want to try to get an answer on --

DR. NEWHOUSE: It seems to me like an important question.

DR. WILENSKY: I agree, but we don't have the answer to it. So we can try to establish whether or not we could have it --

MR. GREENE: In a sense, this question is do you want to proceed along a separate track for applying risk adjustment --

DR. ROWE: [inaudible]

DR. WILENSKY: In the short term, at least. The

question is do we want to proceed in the short term? If we can get data from 25 programs that we can't get from 500 programs, do we want to move it ahead faster? Or do we want to postpone it? That is clearly a question.

DR. NEWHOUSE: Peter wants to say no.

DR. WILENSKY: I understand.

MS. ROSENBLATT: And I just want to point out that I think there are two sides to that question. Not only do they have the encounter data, but can HCFA by a certain date, whether it's 1/1/2000 or 1/1/2001, process that new data for this small population in addition to everything else they're trying to --

DR. NEWHOUSE: No, I think we'd have to do the HCC model as was developed.

MS. ROSENBLATT: And the question I'm raising is can HCFA process that?

DR. WILENSKY: If this is what the majority of commissioners would like, we will try to establish whether or not it is available, whether or not it could be put into effect in time, between now and the April meeting.

MR. MacBAIN: Back to Mr. Pope's table on

predictive ratios for risk adjustment models. In looking at the PIP-DCG versus the HCC columns, the little asterisks demonstrate that the differences from one are statistically significant. What is the significance between those two columns?

In other words, do we really gain statistically significant predictive value by adding the outpatient data, given that they both still have an inherent error?

DR. LAVE: We don't gain a lot by doing that. If you look at the data that Greg put together, you gain by something by --

MR. MacBAIN: Do you? My question is do you? You appear to gain something, but is it statistically significant? Is the difference between a ratio of .72 and .88 a real difference?

MR. POPE: I have not done that test so I would guess that that's a fairly real difference, but I can't say.

MR. MacBAIN: That's a question we want to answer before we try to add the other data.

Also, on that same table, just so I understand it, the first column with the heading comprehensive survey, are

those that show the predictive ratios of just the survey alone, without using any claims data?

MR. POPE: Yes, and also it's self-rated general health as well as functional status and self-reported chronic conditions.

MR. MacBAIN: But it appears that that survey by itself is as predictive as adding the claims data. That adding the claims data to the survey doesn't add anything. So if we simply use the survey by itself, we would do just as well as going through all this other stuff.

MR. POPE: For this particular --

MR. MacBAIN: For this population, but that's what we're talking about.

MR. MacBAIN: If you insist on introducing practicality into this.

DR. KEMPER: I guess I'm not clear what's being proposed here, though, because if it's just using the HCCs in a special way for PACE, then we're sort of ignoring the point of the data analysis that's been done. The real thing that needs to be done for this group is to get the functional disability in there.

DR. NEWHOUSE: We need to talk about that.

MR. GREENE: That's the next recommendation option.

DR. KEMPER: So it seems to me that, given HCFA's scarce resources, to put a lot of effort into developing something special to get us to HCCs does not make sense.

DR. NEWHOUSE: They've got it on the shelf.

DR. KEMPER: Not with ADLs in it.

DR. NEWHOUSE: No, you wouldn't have ADLs. As I understood this recommendation, it was just HCCs or claims-based.

DR. LAVE: It doesn't solve much of the problem.

DR. KEMPER: It doesn't get you --

DR. WILENSKY: Let me try to --

DR. NEWHOUSE: The issue is which claims, if it's a claims only system.

MR. GREENE: For your information, HCFA has announced as part of their postponement, they'll be working with the specialized plans to collect ambulatory and functional status data. That haven't indicated if the data's available immediately or anything different.

Briefly, just responding to that, and finishing the recommendations beyond the question of application of claims models, would be to try to use non-claims based models which basically means the survey data that we're talking about or survey data combined with claims data.

And finally, raising the separate issue of -- okay, this is using non-claims based data. That is, survey data alone or in combination with the claims data, which sort of follows the alternatives that Greg was laying out, the survey models alone or the HCC.

DR. WILENSKY: But is our question first -- do we have a first question of, do we support the short-term postponement? And then do we want to do these others? Is that the way you see the hierarchy of recommendations?

MR. GREENE: Yes, I think so.

DR. CURRERI: Let me ask you a question. When I look at this variation and the R-squareds, even the best, which is the HCC plus the survey, is explaining roughly 8 percent of the variability as compared to 6.5 or 6.6 percent with the PIP survey. So we apparently have 92 percent unexplained, random.

DR. NEWHOUSE: No, it doesn't follow that it's random.

DR. CURRERI: So it seems to me that the differences between these two are very little, in terms of totally explaining or predicting as compared to the unexplained part, which is 92 percent. Am I wrong about that?

DR. NEWHOUSE: Yes, you'd want to take it as relative to what you could potentially explain. So that's probably more in the 20 to 30 percent range.

MR. POPE: I think the difference is between looking at individuals versus groups where those R-squareds are telling you you're not doing well for individuals on any of the models. But if you have a lot of individuals that are say impaired in the average over all of them, then you can do better for that group, meaning a group average with a large group of people with the additional functional status or ambulatory diagnoses. So it kind of depends on how many people you're talking about.

MR. MacBAIN: That raises another point though because in most of these plans we're not talking about a

large group of people. They're fairly small numbers of enrollees which further deteriorates the validity.

I think what your table here shows is that the claim-based systems are not valid risk adjusters in these groups.

MR. POPE: It would mean those plans may be subject to a lot of unsystematic risk, you know random risk. And they may need other methods of dealing with that kind of risk, financial risk.

MR. GREENE: That also raises the fourth and last of our issues and recommendation options is to apply risk-sharing methods to these plans, outliers provisions, phase-in partial capitation. The question is is that more applicable to these small specialized plans? There's something to be said for that.

Over and above any risk adjustment that you apply, is this a situation where --

DR. NEWHOUSE: I think if we can get encounter data then I think the case for partial capitation becomes stronger. And let me say three problems with the functional status measures, which I'd be happy to hear Peter on because

I think he's on the other side. All of these have come up, so I'm really interested in your response to this.

One is the creep issue. There's somewhere, by my calculations, like 20 to 50 percent increment for coding one ADL. That seems like a pretty strong incentives.

Then the second is Jack's point about improvement. I mean, this has vague overtones of why we don't adjust the AAPCC for death. You would lose a lot of money here if you improve the person.

And then the third question is the feasibility of getting it from the chart, or at least when you could do that, or if you are in fact talking about surveys to get it because surveys seems to -- the non-response issue in particular seems to be a potential problem in surveys.

DR. KEMPER: My personal response is, on the last one, I think if it requires surveys it's not going to work.

DR. NEWHOUSE: So it has to be chart-based.

DR. KEMPER: That's my feeling. I just think that the surveys are so expensive and so mutable, but other people may disagree about that. But I do view it as a clinical measure. Certainly these programs have it in their

records already, I would wager, very well.

On the question of creep and incentives to do the wrong thing, in terms of --

DR. NEWHOUSE: It actually could be a variant of creep. The person may have, in fact, improved but somehow that didn't get recorded in the chart.

DR. KEMPER: Accuracy of the ADL measure is one issue. If it changes behavior so you don't give therapy so people don't improve, that's a much more serious issue and would consider that less likely but something that we'd have to pay attention to.

On the creep and misreporting, I think we face that in spades with all the encounter data, the reporting --

DR. LAVE: The RUGs?

DR. KEMPER: And the RUGs, as well. It's not unique to ADLs in terms of creep and misreporting.

DR. NEWHOUSE: That's actually another reason that tilts me toward partial capitation, because the under reporting, I think, is much more serious on diagnosis than on the fact of the encounter.

DR. KEMPER: Right.

DR. NEWHOUSE: Or potentially even what services were rendered.

DR. KEMPER: But I think all the reporting is going to change dramatically once the payment is based on it. So I think that applies across the board.

My concern is this is a very frail and vulnerable group that, that the plans are going to have a strong incentive to select against.

DR. NEWHOUSE: That leads me to a second question about the PACE program in particular. My takeaway from our earlier discussions of PACE, and I'd be happy to have someone say I'm mistaken, was that who exactly was eligible to come into PACE seemed very ill-defined to me. It looked to me like, you know, it's been kind of a tiny program of mostly missionary-like folk, as I read it.

But now it's opened up to entry and we put this big pot of money, 2.39 times the AAPCC out there, and exactly who you're entitled to collect this for seems, as I say, pretty ill-defined. Is that fair or unfair?

MS. THOMAS: That's fair except no for-profit entities are permitted to contact as PACE providers.

DR. NEWHOUSE: Really? I thought the for-profits were permitted.

MS. THOMAS: Only in the demonstration. There's a demonstration that hasn't gotten started for for-profit entities. One of the things in the BBA --

DR. NEWHOUSE: I guess the point being whether it's for-profit or not-for-profit --

DR. KEMPER: It doesn't mean the incentives don't matter.

MS. THOMAS: But I raise that as something that our Commission has addressed with commenting on it.

DR. NEWHOUSE: Say again?

MS. THOMAS: Our Commission in the BBA is charged with commenting on whether it would be appropriate for for-profit entities to participate.

DR. NEWHOUSE: Either way

DR. WILENSKY: But it strikes me that the eligibility issue, the coverage eligibility issue, strikes me as a much more appropriate --

MS. THOMAS: That's what I thought Joe was first going to get at, is what people are allowed, rather than

what providers are allowed.

DR. NEWHOUSE: Yes, I was.

MS. THOMAS: There was a recent study that was commissioned by HCFA. It's the Research Triangle Institute contracted with the University of Wisconsin. They looked at the variation in nursing home viability criteria across states. And they found quite a bit of variation but a lot of overlap.

DR. NEWHOUSE: You have to be nursing home certifiable to get into PACE?

MS. THOMAS: You must be nursing home certifiable but the state criteria vary.

MR. GRUENBERG: I just wanted to say that in order to get into PACE, the state has to approve you, that you're nursing home certifiable. And then they are on the line to pay much more than Medicare. So there is a self-correction.

DR. NEWHOUSE: Why are they on the line?

MR. GRUENBERG: They have to pay the Medicaid capitation, which is higher than the Medicare. PACE gets paid from both, Medicare and Medicaid.

DR. WILENSKY: I would like, if we can, to get a

sense on this, because let me share with you what the plans for the rest of this period is. Complete this and make recommendations.

I want to do the sessions that we did not do this morning. And then we will break for lunch around 1:00 o'clock and then continue with the afternoon schedule. So we have a substantial amount of work.

It seems to me our first question is do we support postponement of risk adjustment as proposed by HCFA? That is, it seems to me, a first level question.

MR. GREENE: If you don't, it almost closes the issue on --

DR. WILENSKY: I personally am in favor of postponing this. I don't think we are ready to make moves. What I really want to know, is there anybody here who is not in favor of the postponement that HCFA has proposed?

DR. KEMPER: Can we couple with that a statement of the long run objective of mainstreaming?

DR. WILENSKY: I think we're going to do it as a second recommendation because -- let's see where we are. In the first place, it's stronger I think to have

recommendation one as we propose a delay.

DR. KEMPER: I agree.

MS. NEWPORT: That's one year, right?

DR. WILENSKY: If that's what HCFA has proposed now.

MR. GREENE: That's what the currently propose.

DR. LAVE: Let me raise this question, do we want to recommend it only for PACE or for all of the programs?

DR. CURRERI: Do you think there are enough people in the PACE program to get reasonable outpatient ambulatory data and apply it? I mean, with 21 programs, what's the average number in each PACE program?

DR. LAVE: PACE and EverCare.

DR. WILENSKY: I think SHMO is -- I don't have a strong feeling. PACE and EverCare we definitely want to postpone. I don't know enough about the SHMO. I mean, I remember the tables that you showed us last year but I don't have a strong feeling on it.

DR. CURRERI: Could you give me an approximate number of the total people in PACE right now?

MS. THOMAS: I think it's in your mailing

materials. I put the information from last fall in there towards the end. There's two tables. The enrollment in the PACE program, the high is 800 at Onloc and the average is something like 200 or something like that. So with all these new entrants it might even be lower.

DR. KEMPER: Just a simple --

MS. THOMAS: SHMO has a high of 70,000 in one plan.

MR. GREENE: Yes, and one scan is 3,500 or something.

DR. WILENSKY: If we don't include the postponement for SHMOs, then by implication they just go into the regular risk adjustment?

MR. GREENE: Yes, they would just go into the regular PIP-DCG pot.

DR. NEWHOUSE: 10 percent of the way, right?

DR. WILENSKY: 10 percent, like everybody else.

MS. NEWPORT: You still have to do all the claims for your inpatient.

DR. WILENSKY: Jack, do you have any objections if we were to put the SHMOs with the rest of the population?

DR. ROWE: No, I like Judy's argument based on my experience. Based on my experience, I think the distance between the regular population and SHMOs is real but it is much less than the difference between those and PACE, much different.

DR. WILENSKY: Then we're going to recommend the postponement for PACE and EverCare and not for the Social HMOs.

With regard to where we want to recommend that HCFA go from here.

DR. KEMPER: Can I just comment on the partial capitation? Because as a general proposition, I'm very sympathetic to partial capitation.

DR. WILENSKY: Other than the fact that no one ever seems to want to adopt it.

DR. LAVE: This is a small enough group. We may get away with it.

DR. KEMPER: I think there's a real problem with partial capitation when the objective of the program is substitution into some kinds of services that are not normally covered by Medicare. So to calculate the partial

capitation, you would be calculating it on, for example, hospital costs and, in fact, you're trying to substitute away from hospital costs.

DR. NEWHOUSE: With what?

DR. KEMPER: By adult daycare, which is not --

DR. NEWHOUSE: So we would need some kind of schedule for adult daycare.

DR. KEMPER: It gets you into a whole can of worms. Plus you've also got the Medicaid service cost as part of this, and you're substituting across services. So it just gets very complicated.

DR. WILENSKY: I think it's not clear that it is desirable.

MR. MacBAIN: I think it depends on how you calculate it. If the base capitation is high enough, the incremental revenue from a hospitalization would be offset by the cost to the extent -- so I think it's possible. It's going to take some work but I think it's the right direction.

DR. NEWHOUSE: Peter is still right. You don't want to have positive marginal revenue for the hospital and

zero marginal revenue for adult daycare. You want to stay neutral.

MR. MacBAIN: It's a difference between marginal revenue and marginal cost.

DR. NEWHOUSE: So you'd like to pay marginal -- well, you'd like those equal.

MR. MacBAIN: Yes.

DR. WILENSKY: Now in terms of what it is we want to recommend HCFA move toward...

MR. GREENE: Move towards HCCs or other possible -- sooner here? I think that depends on the availability of encounter data. We have no reason to think that encounter data is more available for the SHMOs than for the other plans. But no indication --

DR. LAVE: But the encounter -- but we also heard the encounter data won't solve the PACE problem.

DR. CURRERI: Not for the SHMOs. The SHMOs are 55,000 people.

DR. NEWHOUSE: We don't think it will solve the PACE problem.

DR. LAVE: But we don't think it's going to solve

the problem of targeting on high risk patients. So I think that it's better, but I don't know why it is sufficiently better for this population, you want to focus on this population.

DR. WILENSKY: So is it really then to develop methods that are allowing survey based and hybrid risk adjusters?

MR. GREENE: Mainly survey based and hybrid methods.

DR. NEWHOUSE: Now are all of these -- I'm not sure I want to buy survey based.

DR. KEMPER: Can I suggest, this is sort of like the medical liability. Can we shift from equating survey based and disability measures to using the term disability measures?

DR. WILENSKY: All right, sure.

DR. NEWHOUSE: What percentage of the PACE population has zero ADLs?

DR. WILENSKY: That's a good distinction.

DR. LAVE: Probably zero.

MR. GRUENBERG: No, maybe 5 percent or 8 percent.

MR. GREENE: Very few.

MS. NEWPORT: Shouldn't these disability measures be --

DR. CURRERI: And remember, there are only 400,300 people on the books.

MS. NEWPORT: -- applied across the board to all Medicare as opposed to --

DR. CURRERI: You can't go off by more than 10 a year.

DR. WILENSKY: It depends. If you can do special surveys are you going to want to --

DR. CURRERI: Or the most you're going to have is 2,000 a year.

DR. WILENSKY: I mean, that's really the question.

MS. NEWPORT: If there's value --

DR. WILENSKY: There's cases for a highly disabled population.

MS. NEWPORT: I guess what I'm saying is the value, if you're going to do risk adjusters for these folks for the same type of individuals that are in other plans, don't we want to apply these broadly to Medicare as a whole,

as opposed to just this subset of entities?

DR. WILENSKY: I would think that once we have these available, for this population for which we clearly need them, then the question is whether or not we can and wish to pay for data collection comparably for the other 90-plus percent of our Medicare population.

DR. LAVE: I think Peter started off with a recommendation --

DR. WILENSKY: That's clearly where he would like to be.

DR. LAVE: -- with a statement that we would like to have a system that paid everybody the same way. So maybe we ought to go for postponement. We ought to basically say that doing HCC is not going to solve the problem. That this is a small enough population and group that can hold them on a special route and that you worry about developing measures for the full population to take into account frailty and not focus it only on this population.

DR. WILENSKY: I think we ought to start with the principle that was discussed that we would like to pay on the same basis, but that we are recommending postponement

and development of these disability based measures in this limited population and for presumably use to the rest of the population once we develop them. This is a group for which we must have them. We want to hold them out, we're not holding the rest of the risk adjusters up, but I think having the principle on paper that we ought to use the same method for the whole population indicates where we want ultimately to go.

DR. NEWHOUSE: There is one difference, which is the big difference between zero and one becomes a much more important problem for the whole population than it is for this population. I don't know how to get around that.

DR. WILENSKY: The preferred principle of being able to pay on the same basis, I'm comfortable with.

The issue of once you've decided what that looks like whether you think you can implement it or not, I don't know, I think we ought to postpone. I think we don't have it.

DR. KEMPER: I think it's consider. There's a lot of feasibility questions around using disability in risk adjustment. So I don't think we can say we should use it.

But they ought to work on it.

DR. NEWHOUSE: So the recommendation is work toward it for this population or for the entire population?

DR. KEMPER: I would say for the entire population because the first principle, to me --

DR. NEWHOUSE: I think at least in the text ought to take some cognizance of the fact these are different populations and problems may be different.

MS. NEWPORT: If it's an individual risk adjuster and these are various site-specific entities that aren't generally available in some markets, there may be people who are equally sick. So the idea is you adjust for the cost of that individual.

DR. NEWHOUSE: No, I understand the general principle. I'm just very concerned about starting to code somebody -- going from zero to one with the general population.

DR. LAVE: Because it increases your payment rate by 100 percent?

DR. NEWHOUSE: Tim and Sarah, do you have enough to go with the June report?

MR. GREENE: You're saying develop for this population with concern applying. Are you saying develop and apply for this group?

DR. NEWHOUSE: We certainly embrace the principle of neutrality or a similar method across the whole population in a recommendation. And I would have personally said the text ought to have some skepticism about how fast you can move in the general population.

MR. GREENE: Are you suggesting applying it to these plans first, whether or not you can expand?

DR. NEWHOUSE: I'm comfortable with applying it to these plans first. How about others?

DR. LAVE: What did you say?

DR. NEWHOUSE: The issue is should there be some language about applying a functional status measure in these populations first?

DR. CURRERI: I just wonder about the fairness of that. Suppose you're in rural Alabama where there's one HMO and you're old and you're frail and you have all these disabilities but that's your only managed care plan. Shouldn't they be paid for that extra frailty?

DR. LAVE: The answer is yes and that's where we want to go.

DR. NEWHOUSE: I think the answer is yes, they should be.

DR. CURRERI: I mean, you're not going there by --

DR. NEWHOUSE: You do have the option of traditional Medicare. In fact, my guess is there's not too many at-risk plans in rural Alabama.

DR. CURRERI: There are some.

DR. NEWHOUSE: It's 1 percent nationally the last time I looked, in rural populations. Yes, I think the answer is you would like to be neutral if you could be.

MR. GREENE: Do you have any final position on the final capitation, outlier and such, risk sharing?

DR. LAVE: I think Peter has persuaded us against the partial capitation for this group.

DR. NEWHOUSE: I think you'd have to say partial capitation in this group would require payment of certain non-Medicare covered services and therefore, that's what we're recommending. And the Medicaid.

Thank you very much, Lenny and Greg. Good to see

you.

Okay, so we're going to try to do end of life with Andy and David. I'm sorry, we didn't do public comment. Before we start this, is there any public comment on anything so far this morning?

MS. WILBUR: Thank you, I'm Valerie Wilbur. I'm a private consultant and I do work for both the Social HMOs and the National Chronic Care Consortium, which represents about 40 integrated networks across the country, many of which have regular M+C plans, not Social HMO plans.

I think it's important, in terms of the payment, to distinguish between the risk adjustment as it's applied across all HMOs, not just the Social HMOs, and how they get paid for that on the basis of frailty. Distinguish that from payment related to additional benefits for the long-term care services, because as was pointed out, the first generation Social HMOs are required to provide prescription drugs, additional primary care, plus the long-term care benefits like the home and community based services.

The second generation Social HMOs aren't required to provide those services but they are required to do a lot

by way of screening, assessment, development of special geriatric protocols. And what the Social HMO consortium itself has put on the table for Congress to consider is, in making us permanent and in exchange for continuing to get a special risk adjustment that we, in legislation, should be required to provide those additional primary care benefits, the long-term care benefits, and the additional development of ongoing geriatric assessment tools.

I think it's real important to distinguish between those two components.

DR. NEWHOUSE: Thank you. Do you have a position on that, in terms of the Congressional proposal to do that?

MS. WILBUR: Yes. We've actually shared that with your staff, Dr. Newhouse, about what our proposal is for how Social HMOs would become permanent. And we have said that we should be required to provide these additional primary care benefits that SHMO-1's are required to, that we actually put in a specified amount of long-term care benefits that we would be required to provide. And we have a whole page of what we're supposed to do, relative to clinical assessments and geriatric protocol development.

DR. NEWHOUSE: Maybe we need to take this up next time and go back and reconsider the discussion and where we came out on the SHMO recommendations. Thank you.

MR. CHINCHANO: I'm Dolph Chinchano from the National Kidney Foundation. I want to thank the Commissioners for their concern about the nutritional needs of dialysis patients and also to comment about the interrelationship between the quality indicators that were provided in the discussion of the ESRD program.

There is indication that people who are malnourished and dialysis patients who are malnourished are more likely to be hospitalized. So there is a relationship between those five quality indicators, as has already been pointed out.

Finally, I'd like the Commission to know that the National Kidney Foundation Dialysis Outcomes Quality Initiative will be producing a fifth guideline, specifically practice guidelines in the area of nutritional support for dialysis patients. And those guidelines will be available in the next two months.

Thank you.

DR. NEWHOUSE: Thank you. Lenny, further thoughts?

MR. GRUENBERG: I just wanted to add a comment. I was associated with a Social HMO at its outset but I haven't really been for a number of years. But I have been doing quite a lot of research using the Social HMO data.

I believe that if you really force the Social HMOs to accept the PIP -- go mainstream and accept the plans for the payment model, that they would all close. So I think that before you make that recommendation you should really think very carefully if that's really what your aim is.

I don't think that any one of them could stay in existence if they had to.

DR. NEWHOUSE: You're talking about both the first phase and the second phase?

MR. GRUENBERG: The second phase already has a different method that's being used, using the survey method. The first phase, I don't think that any one of them could stay open if they had to be folded into the regular AAPCC.

DR. KEMPER: Is that because of the greater frailty or the additional benefits? Or how much is due to

that?

MR. GRUENBERG: First of all, they currently get -- I don't think that they're making a lot of money.

DR. LAVE: No, that's not the point.

MR. GRUENBERG: They currently get 100 percent, so immediately there would be a 5 percent drop. They have something like three times as many people that are NHC or ADL-impaired, as the general population. And the PIP model is severely biased against that.

So they would really be getting a double reduction from the 5 percent and also the loss because they have too many frail people.

DR. NEWHOUSE: Sounds like we should have some further discussion of this on the next meeting?

DR. KEMPER: And maybe some numbers.

DR. ROWE: It may be that my experiences with SHMOs are SHMO-dependent or SHMO-specific, and they may not all be the same. All SHMOs, you turn them upside down or something and they're all different instead of the same.

And then we have the new SHMOs and the old SHMOs and it's a little confusing here. Maybe we could get a

table with the patient characteristics or something like that, that would help us reaffirm or not our decision the next time we do that.

DR. NEWHOUSE: Yes. Sarah and Tim, did they hear this? Sarah's hearing this last discussion.

DR. ROWE: We exhausted them, they left. Do you have an opinion on this?

MS. THOMAS: In that table of demographic characteristics, I did provide the actual age information and mortality rates.

DR. ROWE: Yes, but the NHC --

MS. THOMAS: It's a little harder because they're not in any Medicare data set. So we can certainly bring to you information from the evaluation and information along those lines. And anything that Valerie gets us.

DR. ROWE: As unusual as it may be for MedPAC staff, you might look at another data set, rather than a Medicare data set.

MS. THOMAS: Right, and we can certainly get information from the SHMOs themselves directly.

DR. NEWHOUSE: Any other public comment? Andy and

David, you're on.

MR. SHAPIRO: Thank you.

This is a draft chapter and it would be most helpful, as usual, if you focus on the recommendations for us. We'll keep our remarks very brief because of the time.

The overriding message of the chapter is that care at the end of life should be made a national quality improvement goal for Medicare. There are three sections in the chapter.

The first is about measuring and improving quality of end of life care. The section describes the vital role that quality measures play. When I began work I expected to find there were very few available, but I was pleasantly surprised to find there are many measures of quality of care that can be used for end of life care. Their limitations, of at least 1996, were that few had been specifically developed or adapted for populations at the end of life, and that there were some practical challenges in using them that had to be confronted.

Since then there's been quite a lot of work, mostly funded by private health care foundations, to improve

quality and to use measures to try to assess whether they're being successful or not. I think there's no reason why Medicare should be left behind or should lag behind. Medicare can begin quality improvement projects, both on a local and regional level, in traditional Medicare and in Medicare+Choice.

The private accrediting organizations are working on measures for accountability and public comparison of quality of end of life care, but they're not going to be available except in a few cases where the field is much more developed for use in the near term.

The second section deals with advance care planning. It describes the limitations of the Patient Self-Determination Act and advance directives on hospital admission and suggests we should move our focus to advance care planning, which is conceived much more broadly as something that occurs much earlier in the disease process, focuses on say people who have chronic, ultimately fatal, diseases and goes over with them what their current condition is, what their likely trajectories might be over the next year or two, and ultimately tries to figure out

what kind of mix of curative and palliative treatment they would like to have or is appropriate for them over time and as it changes.

The recommendations address that we should clarify payment for advanced care planning and two specific examples of the more general recommendations that we should work on measures of quality for advance care planning and begin quality improvement projects to try to increase the use of it. Andy?

MR. COSGROVE: Thank you, David.

At the end of the 30 years war, the lands of the Roman empire lay in ruins. Well, I know we're behind so I'll skip some of this introductory stuff.

[Laughter.]

MR. COSGROVE: This last part of the chapter just talks about hospice, saying that yes, it came in in 1983. I think most people agree that it has generally served the patients that it does serve pretty well. However, these tend, most often, to be cancer patients. The eligibility rules for hospice are structured such that it fits the cancer model very well.

It describes a few factors that could limit participation in hospice, the six-month diagnosis rule, the home caregiver which isn't necessarily a rule but it sort of works out that way a lot of times, cultural factors like difficulties in communication that could arise. These types of decisions as to whether to enter a hospice or end of life care in general can be about the most important discussion you'd ever have. You don't need anything standing in the way of that. That can be hard enough.

Based on some of these, we just had proposed a possible recommendation. I know recommending further research is always controversial, but further research on coordinated care at the end of life, given some of the factors that may limit hospice participation.

DR. ROWE: Do you want to go straight to recommendations?

DR. NEWHOUSE: Yes. That would certainly get us to lunch faster. However, I was going to raise the issue about the incentives for the use of advanced directors and David, what you had in mind. You cite the LaCrosse experience but that seems -- you know, there's nothing that

I can see from the HCFA side that could encourage that elsewhere, or maybe there is. How did you envision that that might spread across the land?

MR. SHAPIRO: The only direct means that HCFA has right now, I think, are working through the QIOs and working through Medicare+Choice plans, as part of their quality improvement.

DR. NEWHOUSE: I was thinking a radical thought. I was thinking you'd get a little break maybe on your Part B premium if you had advanced directive.

MR. SHAPIRO: Well, I think this is kind of a subset of a general quality chapter that's Beth's going to be presenting and that we've looked at before. As these other means of influencing quality are used, whether it's selective purchasing, differential payment, incent bonus payment, rewards, whatever, they're certainly available to be used for this. And if you want to propose that, that's fine.

DR. NEWHOUSE: I'll see how people react to that.

DR. LAVE: I have a question and this is a question that's basically directed towards the physicians

present. That is I was at an end of life conference and Joe was at the same conference. One of the issues that came up, as I understood it, is that if I am hospitalized and if I am dying, that you really have to do something for me in the hospital because you've got to treat me. Otherwise, I'm not supposed to be there.

So there were some problems that they felt sort of had some peculiar incentives because of the treatment requirements of being in the hospital had to do with whether or not a physician was giving palliative care, whether or not there was an RVU about that.

Since everybody doesn't have a hospice available in the hospital, there was some suggestion this actually exacerbated some of the problems associated with appropriate dying in the hospital and that Medicare ought to, in fact, reflect on its policies.

So I'd like you to talk about this and see whether we ought to focus on it.

DR. ROWE: I'll tell you what I know about where we are and maybe we can get some data on this. There is a palliative care DRG, right?

DR. NEWHOUSE: That's a demonstration DRG.

DR. ROWE: That's a demonstration DRG.

DR. NEWHOUSE: And as I heard you the last time, that got the IG into your hospital.

DR. ROWE: The IG comes every day, but I'm not alone. They come to all the academic medical centers every day.

But there is a demonstration project underway with a palliative care DRG in order to try to get around it. I would assume that the reason patients at the end of life, who are irreversibly, irretrievably ill and really should get palliative care, get more diagnostic and invasive care is not because of the Medicare issue, because the doctor per se really doesn't care whether the hospital is getting paid or not, but because doctors don't know enough about how to take care of patients at the end of life.

So they have this treatment methodology and so do the residents and they're ordering stuff that they shouldn't be ordering and doing things they don't need to do. But I doubt whether it's so distorted that it's induced by this Medicare payment policy.

DR. LAVE: Would you have a different -- would it be a shift in mindset, I guess, if we changed what was going on?

DR. ROWE: I would like to think that -- my opinion is that we should really focus on where the real problem is. And the real problem is, I believe, unfortunately not noted in this chapter. And I think this is great. Of all the things we do in this Commission, me as one guy, I feel best about this. You will go to heaven if you can improve the health care at the end of life of our Medicare beneficiaries. I believe that.

MR. SHEA: And the corollary to that is?

[Laughter.]

DR. ROWE: The corollary to that is, no change from the previous. I really believe, and I'm not going to give my speech again because I gave it in November and it didn't make it into the stuff.

DR. LAVE: Give it again, this time it will go on.

DR. ROWE: If you don't want to do it, you don't have to do it, but I'll feel better if I tell you. The problem in American medicine with care at the end of life is

that nobody trains doctors in care at the end of life. They should be residency training requirements. We should have training of doctors on how to take care of people when they're dying. It's not mentioned in this. It needs to be in there somewhere, that we need to have some kind of an effort to train doctors on how to take care of these patients.

And we can use our influence. We have a recommendation that says work with private accrediting bodies as they develop and use measures to accredit health care organizations. Well, the hospitals aren't going to do it. We have to get the American Board of Internal Medicine, the RRC, and all the rest of these groups to tell training programs that you have to teach your residents, particularly internists and family practitioners, something of the principle to taking care of people at the end of life.

End of speech.

DR. NEWHOUSE: Would you like that to rise to the status of a formal recommendation?

DR. ROWE: I haven't been able to get it in the narrative. If I can get it into a recommendation, I'll take

it.

DR. NEWHOUSE: Let's see how people feel about that.

DR. MYERS: I like Jack's proposal. That's wonderful.

On your issue, is there a precedent for any other discounts to Part B premiums anywhere?

DR. NEWHOUSE: Not that I know of.

DR. MYERS: Is it something that would be currently permissible by statute or would it require a new law? Have we talked about this before?

DR. ROWE: There was one recommended recently in an editorial in the New England Journal about preventive health and discounts.

DR. NEWHOUSE: No, I think it would require statutory change.

DR. MYERS: I very much like the idea. I think obviously you have to be cautious and with respect to the advance directives, there are a lot of cultural issues that need to be considered in terms of how one applies it and the enforceability issues, et cetera.

But I think that if there is a way for us to explore what such a discounting system might look at, I would be in favor of doing that.

DR. NEWHOUSE: Maybe we ought to put it on the agenda for the future.

MR. MacBAIN: I think the LaCrosse studies is very interesting in its ability to gain compliance with an advance directive. My concern is that simply getting an advance directive signed may not produce a whole lot. And to generalize from a specific anecdote, which is the most valid statistic of course, but I still remember talking with an HMO medical director who routinely reviewed the charts of members of the plan who had died and describing going through a typical two-inch or three-inch chart only to find the advance directive buried at the bottom of it.

DR. ROWE: There are data on that. Studies support that.

DR. NEWHOUSE: I agree with that.

MR. MacBAIN: Simply getting the document signed, regardless of which direction it directs care, may not have a whole lot of impact on what actually happens to the

patient. And the LaCrosse approach of community education, institutional education, dealing with the folks who are actually making decisions at the end of life, including the patient but also other people, probably has much more impact on what happens than any piece of paper.

DR. NEWHOUSE: I know the support data and I think the issue is, and maybe the LaCrosse data would let us sort it out, that if advance directives became much more prominent that the paradigm might shift, that they wouldn't be ignored. But you have to take that on faith, I think.

MR. MacBAIN: Theoretically they're being -- at least the opportunity is offered to every Medicare beneficiary that's admitted to a hospital now.

DR. NEWHOUSE: Right.

MR. MacBAIN: So the concept is prominent.

DR. ROWE: In some states, all patients.

MR. MacBAIN: But I'm not sure it's done anything.

MR. JOHNSON: I'd like to agree also with Jack on some of his earlier comments, but speaking from a hospital administrative point of view, we can document anything. In fact, we document everything, including those things that

probably shouldn't be documented, as Jack might say.

In a way, it's sort of like organ donation. There's a lot of documentation relating to organ donation now but it's still sort of a cultural issue in the medical environment, who's going to approach the family? Who's going to draw the short straw to go talk to them. As we were talking about earlier yesterday, we were talking about autopsies.

Welcome to our institution and there's DNR, there's an organ donation, and then there's an autopsy. I just can't wait for the new group of admission clerks to come on board for this one.

But going back to what I would call the horrific events in Michigan over the last couple of years with a pathologist by the name of Dr. Kervorkian, we've been doing a lot of work in Michigan and it's really from the cultural treatment point of view that we're looking at. And it's not just Medicare patients. It's all patients, because certainly his victims were not necessarily Medicare patients.

And the idea of palliative training, which we're

working with the state health department and our osteopathic and allopathic medical societies, we're just doing a round of video teleconferences throughout the state with physicians and other caregivers, and just the heightened public activity surrounding this and understanding it, like organ donation, is what's required.

So I guess a couple of things. One, there's not a vacuum here and HCFA's not alone. But their efforts for the elderly ought to be tied into other ongoing efforts. And again, as Jack said, if we could not only get narrative but a recommendation about palliative treatment education, that would go a long way for both the patient and the physician.

And then just to make a note of another national activity, Robert Wood Johnson Foundation and the AHA and AMA and National Hospice Organizations and the American Association of Homes and Services for the Aging have actually announced an annual competition for a Circle of Life Award, trying to identify two or three cases in the country every year that do an exceptional job of doing this.

So again maybe some of this can be distributed as education and shared. But I think it's community wide. I

think it's a lot toward treatment. And while I appreciate your economic approach to this, I don't think it's a matter of economics. I think it's a matter of training and culture.

DR. NEWHOUSE: I actually agree that it's culture. I'm just trying to figure out how to get --

MR. JOHNSON: But just to have something else documented in the medical record when they come in isn't the answer.

DR. CURRERI: I think that, Jack, in fairness to the authors, Andy and David, if you'll look on page 17 they did include your stuff.

DR. ROWE: Joe, I'd like to make one comment in response to Spencer's thing. I mean, I don't know how we should do this or whatever, but as a physician in the state of New York who actually has a license to practice medicine that might, for many of you, be pretty scary, every four years -- and I just had to recently do this last month. Every three or four years I have to document that I went to a seminar on infection control.

And I went and our hospital and every hospital

runs them once a month or once every three months in the evening for two hours or four hours, whatever it was. You go in there at 6:30 and by 8:30 or 9:00 you're out. And it's really excellent. You learn about infection control and what's happened in four years, about AIDS, hepatitis and methosone resistant staph in hospitals and in offices and stuff. And I went there and I signed my form and I got my little certificate and sent it to the state and got my license renewed.

We could do that every four years. Not every month, not even every year. I mean, if we got every doctor once every four years to sit down for an hour-and-a-half and be taught the principles of palliative care, that would be a 1,000 percent increase in their current knowledge about this stuff.

So there are approaches to this that are relatively painless which I think would make me feel better as a patient.

MR. SHAPIRO: I want to inject a comment or a question. I agree fully, by the way, about the importance of education and licensing and CME and what not.

We have a fairly detailed extensive section in the workplan in November that addressed education and CME and proposed looking at things like how many states require specific topics such as this in their CME requirements. How many specialties have questions on end of life care in their licensing and certification examinations? How many medical schools have this as specific parts of their curriculum and that kind of thing.

I thought we got a very unequivocal message that we were not going to make any recommendations concerning education and training.

MR. COSGROVE: That was my, also.

MR. SHAPIRO: But that we would try to mention something about it, which it's our deficiency that we didn't put it in this draft. That had to do with just trying to get focused on recommendations and getting that out and not writing the rest of the stuff that went around it.

So the question is, if you've got something that we can easily --

DR. ROWE: Did we change our mind?

MR. SHAPIRO: The narrative text is easy to put in

and I'm happy to draft that for it. I think the question is do you want to change your mind about recommendations? And what's the extent of recommendations? Do you want to just suggest to state medical boards that they consider doing this kind of thing? Is that the nature of what you're talking about? How far are we going to get into this?

DR. MYERS: If Jack's hospital gave that seminar I would go and I would sit in the front row. But that's an awfully slippery slope, to begin to prioritize what we think are the things that physicians ought to do, and then add yet another specific requirement to the list that's starting to grow. I just am very nervous about that.

MR. COSGROVE: Because just this topic in general is sort of out at the frontier of the mandate of the Commission I think. We can certainly recommend anything you want to recommend, but that's always been those challenges. When you're writing, it's how far do we want to go and what exactly do we want to say?

MR. SHEA: Can I argue the other side?

DR. KEMPER: I was just going to remind us of our previous discussion and the fact that the real problem was

not agreeing with Jack's principle of changing culture but the specific recommendations and so on got tinkering around with medical school curriculums and that sort of thing. And I think that's what caused us to back off, was when we got to the regulatory proposals what would we actually do.

DR. NEWHOUSE: Is there anybody that wants to speak for reconsidering that besides Jack? We heard Jack.

MR. SHEA: That's what I wanted to do in the sense that maybe it shouldn't be directed at so many hours and so forth. But I think there's a strong point to make here which is the core one we've talked about before, with the amount of money that Medicare is putting in to support the health system in general, there's something wrong with this picture if we're not getting physicians trained to deal with people for these kind of issues.

I think that's just like simple. I'm not even sure we need to be prescriptive about therefore it means one-and-a-half hours under Jack's tutelage every two weeks or something.

DR. MYERS: We could make it a direct GME requirement, because that is a direct payment.

MS. NEWPORT: You get your GME.

DR. LEWERS: I was going to go to the point that Jack was making without -- and I agree with Woody on that's a dangerous and slippery slope. But in one of our recommendations, on page four, the Secretary should work, which you talked about the accrediting bodies. We can simply change that to include working with the private organizations. I mean, the EPIC program that the AMA has going. That's an educational program. That is a program to start working and getting this in the area.

And I think we could ask the Secretary to work with organizations such as that in the development of accreditation and education of physicians and the public, et cetera.

So I would reword that bottom recommendation to include that information. And quite frankly, while I've got the microphone, I agree with the recommendations that are here, except for number one, which I'd take within the next few years off.

DR. NEWHOUSE: I want to go through the recommendations.

DR. LAVE: I was sort of on the same issue, and what I was concerned about was sort of the order of the way that the material was presented in the chapter. By the time you got the quality factors and hospice care, it lost any immediacy as being really a critical issue.

So I would think that up front in the introduction there ought to be a discussion about sort of the way that we currently do things and the cultural factor that influenced some of this stuff. And then go on, if this is as important as the people who deal with it believe it actually is, that you have problems related to the institution, you have problems related to providers, and then you also have providers related to the patient.

And as we've discussed this, it sort of looks as if the patient is the primary problem. I just think that we may want to restructure and reorder it a little bit.

And then I also agree with sort of putting it into sort of a suggestion in a broad kind of recommendation to deal with this.

DR. NEWHOUSE: Let's go through the recommendations. They're summarized on page two.

The first set is the Secretary should make care at the end of life a national quality improvement focus for Medicare+Choice and traditional Medicare within the next few years.

DR. LEWERS: Take out within the net few years.

DR. NEWHOUSE: Everybody agree with that as amended?

Okay, the Secretary should sponsor projects to develop and test measures of quality of end of life care for Medicare beneficiaries.

DR. ROWE: I have a comment on that. I think we should do one of two things. We should either merge that with recommendation -- I think there are two many recommendations here and I'd like to see if I could consolidate them to have more punch here.

I'd rather either merge it with recommendation number six, which is support the development and testing of measures of the quality of advance care plan, because it's really the same language.

MR. SHAPIRO: It's a subset.

DR. ROWE: It's a subset. You know, you could say

quality of end of life care for Medicare beneficiaries, including advance care planning care.

Or alternatively, five, six and seven all have to do with advance care planning. And we could consolidate those into one major recommendation with respect to advance care planning. It should say something about focus on advance care planning, including....

DR. NEWHOUSE: The latter one is probably easier in the context of the flow of the chapter.

DR. ROWE: I think so, but if you don't want to do that, then you should at least consolidate.

DR. NEWHOUSE: Two on its merit? Any issues on the merits of two? Silence will imply consent.

Okay, work with the private accrediting bodies. Ted, what was your suggested addition to that? And private organizations?

DR. LEWERS: I think that we just that rephrase it in working with, you know, all that's going on in the private industry in this area now. And try to include this and add an educational component for physicians.

DR. NEWHOUSE: So maybe staff will work on some

language and bring it back next time.

DR. LEWERS: David knows what we want.

DR. ROWE: I'd recommend specifically, you might consider, and I think this is consistent with what Ted wants, as you say, work with private accrediting bodies as they develop and use measures to accredit health care organizations and training programs.

DR. LAVE: And physician training programs.

DR. NEWHOUSE: No reason to limit it to physicians.

DR. CURRERI: Maybe hospital training programs.

DR. ROWE: And training programs. And in the narrative mention things like the American Board of Internal Medicine, the AMA, the American Academy of Family Practice.

DR. LAVE: The ANA.

DR. ROWE: The Residency Review Committees, which are sort of half run by the AMA and half by the specialty board. And that will entrain it into a discussion of training.

DR. LEWERS: I think David realizes that's where we're headed.

DR. CURRERI: I would take out the word accrediting between private and bodies and then put a parenthesis, including accrediting medical organizations.

DR. MYERS: Is that strong enough for Gerry?

DR. CURRERI: A lot of these are not accrediting bodies.

DR. NEWHOUSE: We'll presumably have another -- these will pass by our eyes again before they go into the June report.

MR. MacBAIN: Just one concern that may be minor, but we talked about accrediting bodies because of the quasi-regulatory role with regard to hospitals. It brought me back to Jack's discussions about the bluntness of conditions of participation as a regulatory fool. We're beginning to verge a little on that when we start talking about the Secretary encouraging accrediting bodies to start including whatever these measures turn out to be, as an accreditation requirement, which then turns it into a condition of participation.

DR. ROWE: We don't want -- I don't want to get caught in my own trap and I certainly don't want to do that.

But as you are well aware, Bill, it's quite typical now for the various accrediting bodies to require of the institutions things that they didn't used to.

For instance, if you want to train as an internist, you have to document that 30 percent of the time is spent in the ambulatory care environment, as opposed to it used to be all in the hospital. That's not an atypical thing now, for an RRC to require. So we can do that. That's the kind of thing that you would be talking about.

MR. MacBAIN: But not have it creep into conditions of participation in Medicare.

MR. SHEA: I'm sorry I wasn't here for this part of the discussion yesterday because I think this is an important area to address, in terms of how to make the accrediting organization more effective. You're not about to get a lot of initiative within the accrediting bodies in this kind of an area. I think they need a judgment outside of those bodies.

Now maybe it doesn't have to be a condition of participation. I was having a follow up conversation to the session on this yesterday morning about were there other

things that could be done short of making it a condition --

DR. ROWE: Intermediate sanctions short of nuclear warheads.

MR. SHEA: I notice you've been into this kind of cataclysmic language this time. I guess it's been kind of a touch winter and spring up there in New York.

[Laughter.]

DR. ROWE: And this is only year two of the BBA. Wait until you see me next year.

MR. SHEA: One of the problems with the conditions of participation is just the language. But my basic point here is I think it's appropriate for us to recommend and for the program to say this is important to us in this program, and we want it taken into consideration in the accreditation process. Because I don't think the accreditation process is the right generator of that kind of a value judgment. I think it is the programs.

DR. NEWHOUSE: Enlist quality improvement organizations in Medicare+Choice plans to initiative quality improvement programs addressing various aspects of care at the end of life.

MS. NEWPORT: Does that work into the accrediting?

DR. CURRERI: No, because they don't really accredit anything.

DR. NEWHOUSE: This is a different trust.

MS. NEWPORT: There are accrediting organizations for Medicare+Choice.

DR. CURRERI: Yes, but the QIOs aren't then.

MS. NEWPORT: I'm not familiar with those. I'm just trying to see if there's a way to make --

DR. NEWHOUSE: There's the old pros.

DR. CURRERI: They're really an auditing body.

MS. NEWPORT: I'm sorry.

DR. LEWERS: I'm comfortable with that.

DR. NEWHOUSE: Clarify and publicize the availability of payment to physicians for advanced care -- oh, we're going to consolidate these. But we'll see --

DR. LEWERS: We're going to consolidate all those.

DR. NEWHOUSE: Is there any objection to the three of them on the merits? That's fine. So we'll see a consolidated recommendation next time.

Support research, that I trust we will not object

to.

DR. ROWE: I would delete that. I think we've got several specific things we want to sponsor projects to do X and Y.

DR. NEWHOUSE: Then you'd leave some text without any formal recommendation? Okay.

MR. MacBAIN: It's really an amplification of the first recommendation.

DR. LAVE: It's actually very similar to.

DR. ROWE: Yes, I think it's included in there. The fewer of these we have --

DR. NEWHOUSE: Maybe you can work some language about research into one of the others.

DR. LAVE: We've got to keep the hospitals happy and the researchers happy.

DR. ROWE: I'm glad those are your goals. I haven't seen that reflected in your behavior yet. I look forward to that.

DR. KEMPER: And especially the researchers at the academic medical centers.

MR. JOHNSON: Just a comment on this topic under

the rubric of no good deed goes unpunished. As we all sit here and probably feel that we've made a great deal of progress on this item, yesterday I made a tongue-in-cheek comment about maybe we should have a course in school like physical health and how to live in the community on Medicare.

The reason I bring this up, and Bill yesterday was talking about agents on behalf of older people. Just a personal anecdotal experience I had that doesn't require an answer, but those people who are acting on behalf of old people, deferring decisions to the medical community, I had a contractor this winter who was working on some remodeling who was absent for a couple of months because a father-in-law was ill with terminal cancer.

One of our visits he was telling me about how the hospital wanted to meet with him to talk about a care plan outside of the hospital. And the way he and his wife were dealing with her father in this was to avoid meeting with the hospital to avoid meeting with the physician so that he could stay there as long as possible, to avoid anything else so that they didn't have to deal with the actual death and

dying. And that if he could stay there long enough that he either died in the hospital or that the hospital could send him straight to a hospice.

Their strategy in the whole thing as the agent for the Medicare beneficiary was to avoid any involvement in any decision and leave it all to the medical community and the doctor and the medical process.

Especially with our population getting older, and especially if a 93-year-old female is being admitted to the hospital for something or other, I don't know how attuned they're going to be to their DNR or advance directive orders or how attuned those people around them are going to be to actually try and deal with these situations.

So I still think there's something we haven't touched out there in the cultural thing but it's not anything we could legislate. But there is a big, big vacuum on this issue which goes back to more community physician dialogue kind of stuff and education.

DR. NEWHOUSE: Let me ask if there's any public comment on this domain? Everybody's ready to go to lunch who hasn't already gone.

Okay, so it's 1:10. Let's see if we can start about 1:45.

[Whereupon, at 1:07 p.m., the meeting was recessed, to reconvene at 1:48 p.m., this same day.]

AFTERNOON SESSION [1:48 p.m.]

DR. NEWHOUSE: Dan and Judy, you're on. Beneficiary financial liability.

MR. ZABINSKI: Today Judy and I are going to talk about our work on beneficiary financial liability. In the interests of time, I'm going to try to be as brief as possible.

Our financial liability analysis has a lot of similarities to recent analyses but we tried to move beyond them in several ways to improve them. The issues that we address are as follows: the distribution of out-of-pocket spending itself.

What we found is that on average supplemental insurance premiums are the largest source of out-of-pocket

spending. But when you look at beneficiaries with the highest total spending from that, it is not supplemental insurance but out-of-pocket spending on medical providers that is the largest source of out-of-pocket spending. That may be due in large part that there's no limit on out-of-pocket spending on Part B services.

The second thing is changes in out-of-pocket spending over time, and Judy will run through that in more detail in a minute.

And we looked at the distribution of the share of income spent on medical care. What we found was a high degree of variability amongst beneficiaries on that measure. for example, at about the 10th percentile, the distribution of beneficiaries are only spending about 3 percent of their income, but at the 90th percentile they're spending about 40 percent.

Now one thing about the income measure that we used there was that it consist strictly of cash income. But all beneficiaries have a form of non-cash transfers, that being Medicare, and some even have other forms such as Medicaid. One thing we did was we also derived another

income measure that includes not just cash income but also an estimate of the value of Medicare and Medicaid to beneficiaries. And we found that that does make a substantial difference on the income share spent on medical care, especially at the high end of the distribution.

As far as whether we should just work with the cash only or also with the cash plus the value of the non-cash transfer is something that we'd like the Commissioners to comment on and give us some guidance on, as far as how we should proceed with it.

Another is Medicare's effectiveness as a form of insurance. In a positive sense, Medicare is by far the largest source of payment to beneficiaries, covering about 60 percent of their total spending on average. But in a negative sense it does require quite a bit of cost-sharing and it does appear to put some beneficiaries at risk of very high levels of out-of-pocket spending, especially those beneficiaries that have only Medicare coverage.

Finally, we look into the out-of-pocket spending by beneficiaries in long-term care facilities such as nursing homes. And we found that they have a very different

spending profile than the beneficiaries that we looked at in the community. In particular, their reliance upon Medicare is much less than what it is relative to the beneficiaries in the community but the long-term care beneficiaries do rely much more heavily on Medicaid and out-of-pocket spending.

Finally, based upon the results of our work, we concluded that Medicare could be improved as a form of insurance if there was an annual limit on the amount of out-of-pocket spending on Medicare covered services. And we have drafted a recommendation on that point. That's the final thing we'd like the Commissioners to provide us with some guidance on, as far as how we should proceed with that recommendation.

I'd like to turn things over to Judy and she's going to cover the change in out-of-pocket spending over time.

MS. XANTHOPOULOS: I created what I'm calling the beneficiary cohort file, which links by beneficiary ID each beneficiary that's in the cost and use file. The cohort file links beneficiaries that remain in the sample from year

to year.

So what I've done is I have two files right now. One is a file of beneficiaries that remained alive the entire four year period. And we will have the fifth year hopefully by the end of March, so I'll have a five year panel.

So one file has beneficiaries that remained alive for the entire period that matched every year. The other one has people that matched, but in addition may have died during the sample, so that we can look at -- that's a separate issue, I thought, for this analysis, but we could look at end of life issues in terms of spending.

But what I wanted to address with the patterns of spending is to look at what happens to someone over time. If someone was in the highest quartile of out-of-pocket spending or total spending what happened to them in subsequent years, to get at the issue of persistence. Because I think that in the annual files, in looking at a cross-section, someone might have a very high year of expenditures but it doesn't give you an indication of what kind of burden that places on them financially.

It's a considerable difference if it's something that persists or if it's a one year event. So linking the beneficiaries by ID and keeping track of them from year to year gave us a little bit of a different picture.

The pattern that we noticed was that the highest spenders remained high spending throughout the period. The people with the lowest spending remained low. We're in the process of looking at the characteristics of each of those groups and particularly focusing on the high spending group so that we can see what specific patterns and any characteristics about them which might lead us to look at policy decisions, as well.

This is just a --

DR. NEWHOUSE: Presumably the discussion would be like a further reduction in cost-sharing if you hit your limit in several years, or something of that nature?

MS. XANTHOPOULOS: I think what we're trying to say is that on average beneficiaries are doing okay in the Medicare system, but there are some that are going to be hit somewhat harder than others. And that's what we're trying to identify.

We're trying to look at those, and particularly those with persistent levels of spending, high levels of spending. And that's just to try to look at the characteristics and then determine what are the forces that are driving that high spending, and try to see if --

DR. NEWHOUSE: Let's open it up. Thank you for being brief.

MS. ROSENBLATT: I'm a little bit uncomfortable by the recommendation to put a maximum on, because first of all what we're looking at doesn't include drug expenditures which could be a big part of the total expenditures.

I guess it's --

MS. XANTHOPOULOS: It's in the out-of-pocket.

MS. ROSENBLATT: It does?

MR. ZABINSKI: Yes.

MS. ROSENBLATT: The other is, and I don't know how much this is going to cost. I mean, you're recommending that maybe you increase the Part B, but for me it would be helpful to know what does that mean? Does it go from $100 to $150? Does it go from $100 to $125? What's the number? If we could get a quick estimate of that number, that would

be good.

That has implications for Medigap policies and all kinds of things like that, that I think you need to add something in the narrative about that.

MS. XANTHOPOULOS: One of the things that we are looking at in the file is the type of supplemental coverage that beneficiaries have, and trying to address how --

MS. ROSENBLATT: I'm saying something different. What I'm saying is if you increase the Part B deductible, I think you've to change the ten TEFRA plans, which requires legislative change. So I just think you need to mention that in the narrative, if you're going to make a recommendation like that.

You're looking like we don't have to do that?

MR. ZABINSKI: No. As far as recommendation, in the narrative we do mention that possible way of covering the -- you know, an annual limit on the out-of-pocket spending is to raise the Part B deductible. That's just a possibility we put forth. It's not really a recommendation, it's just a possible suggestion as far as how to help cover the additional costs.

MS. ROSENBLATT: Do we know what it's going to cost to put this limit in, in dollars?

MR. ZABINSKI: This is a very, very crude estimation that I did. Annually, I came up with somewhere around $15 billion if you put like an annual limit of about $1,500 on it.

DR. LAVE: I'm very sympathetic towards the recommendation but I think we ought to stay away from it mainly because the recommendation, if we're going to make a recommendation about it, it seems to me that that's sort of putting a catastrophic limit on the Medicare program. If we're going to do that, we should probably also think about the structure of the program.

And I'm not sure this is the right group to actually be making recommendations about fundamental changes in the Medicare program.

So as I said, I'm very supportive of this. I believe that it's a very important issue. We had a Medicare catastrophic debacle in 1988 for a number of other reasons. The linkage with the Medicaid program, the Medigap programs, how these are funded, it's just really very

complicated and I think that there's been some action around that.

You went there and I think it's sort of a recommendation that goes somewhat outside our purview.

MR. SHEA: I'm, like Judy, am very sympathetic to this but, unlike her, I think we ought to see how far we can go. I just think this is a huge issue in terms of the beneficiaries and sure, it's going to be sort of pushing the envelope some to get there, but we look at this data and it shows us there's a problem, just like data in other areas.

Now maybe I'd be convinced at the end of the day that discretion is the better part here, so let me just make that as a first point.

And just, so that I understand it, if there were such a limit it would apply to what, exactly?

MR. ZABINSKI: My thought on this --

MR. SHEA: What's your list of cost-sharing items that this would apply to?

MR. ZABINSKI: Basically anything that's a Medicare covered service right now. So basically prescription drug --

DR. NEWHOUSE: So both A and B?

MR. ZABINSKI: I was thinking of that, yes.

MR. SHEA: So it would be the Part B payments, it would be any cost sharing for Part A or Part B coverage?

MR. ZABINSKI: Right, but not including things that aren't covered, such as prescription drugs would not be.

MR. SHEA: Or Medigap?

MR. ZABINSKI: Right.

DR. NEWHOUSE: When you did your $15 billion, what did you assume for a limit?

MR. ZABINSKI: $1,500 per year.

MR. SHEA: On this question of what's appropriate to consider for income, I think it's pretty fairly done in here, looking at the pros and cons of the various ways of looking and calculating income. But I think it's most usefully looked at in terms of the income measured as cash income, with the caveat that there is a very valuable non-cash item here that some people argue should be considered.

I'm not sure we need to decide that. I think it helps illustrate or illuminate the picture, I guess is what

I'm saying.

I think trying to make a calculation that we should, yes, add that into any calculation goes further than I'm --

DR. NEWHOUSE: If you're going to do it as an absolute dollar limit, then this is just an issue of analysis for our purposes of thinking about it.

MR. SHEA: That's all I'm talking about. I'm just talking about how we describe it in the chapter.

MR. MacBAIN: Just a quick comment on the question of how you measure income. If I have $1,000 cash income and I'm spending $500 on out-of-pocket medical expenses, that leaves me with $500 for everything else.

MR. ZABINSKI: Right.

MR. MacBAIN: If you now tell me that I'm also getting an additional $500 in Medicare benefits, in terms of value, I still only have $500 left to spend on everything else. And in fact, I'm worse off because I'm spending that entire extra $500 on Medicare benefits. So now I'm spending $1,000 or two-thirds of my $1,500 income. So now I'm spending two-thirds of my income.

If you're going to do that, you've got to do it in both numerator and denominator. Personally, I think it kind of fuzzes up the analysis to throw that in.

In terms of the people who are likely to be affected by the cap on out-of-pocket expenses, what percentage of Medicare beneficiaries do not now have some sort of cap as a result of either supplemental benefits or Medicaid or Medicare+Choice?

MR. ZABINSKI: It's about 13, 15 percent.

MR. MacBAIN: So it's about 15 percent are going to be touched by this directly. The rest will see the added value of the cap offset by higher premiums for their supplemental benefits to compensate for the fact that the deductible has now gone up.

So you're moving some money around. People are going to see the same kinds of out-of-pocket expenses but in different categories and about 15 percent may actually benefit from it.

DR. LEWERS: Bill has covered part of what I was going to say, in that it would only affect a small percentage of the population.

But I think that basically what the increasing cost to the beneficiaries, their out-of-pocket expense, in my opinion is but a symptom of the basic problem of the Medicare program that has not been updated. And that's what there's just been a commission spending a year to figure out what to do with that.

There were a lot of things that came out at one point or other. If you go back to the Clinton health plan era, there were discussions about how much the Medigap policies were increasing the cost of the Medicare program. And we had a lot of discussion at one point at PPRC -- I think Joe was still on PPRC when we had that -- about let's get rid of Medigap.

DR. WILENSKY: I was there, too.

DR. NEWHOUSE: All replacement insurance.

DR. LEWERS: Just get rid of it.

DR. NEWHOUSE: Faxes arrived.

DR. LEWERS: Because all it's doing is increasing the cost of Medicare.

MR. SHEA: I remember sending those faxes.

DR. NEWHOUSE: It wasn't your side of this debate,

Gerry.

DR. LEWERS: I disagree with Judy. I think this is something that we have to think about, but I think that this is a much bigger issue than we're ready to tackle right now. I certainly would not want to go with a cap at this point. There are a lot of other problems that need to be addressed.

MS. ROSENBLATT: I'm just going to weigh in. I think I was heading there but wasn't as articulate as Judy and Ted have been. I think that there are many, many problems with the Medicare benefit structure. And to just pick this one without looking at the full range of them, I think, is not the right thing for us to do.

I also think there may be some problems with the $15 billion estimate because you're going to change the whole shift of who buys Medigap if you do something like this. So I just think a more thorough study is needed of what are all the problems with the current benefit structure.

DR. KEMPER: I agree with Alice and the others. By making this sort of recommendation, we're actually going

to undercut our effectiveness in the long run. I don't think Senator Breaux is waiting for additional advice on the subject.

But I do think that in a less direct way we might be able to, at the margin, provide information that pushes in a certain direction. With respect to the document on that score, I thought it could bring out more sort of what the purpose is and what the message is of the analysis, which is quite good, really highlighting the gaps that are there, bringing in the long-term care gap a little more centrally to the discussion.

And particularly bringing out this, finding that the high spenders remain high spenders throughout, because I think what that, to me, says that this out-of-pocket spending is an even bigger issue than it looks like, when you look at it at a point in time. And so I think it's a matter of making the message a little clearer.

On that piece of the 75th percentile group or the top quartile being consistently in that group, I think you might do a little more on that, looking at the composition of the expenditures. If it's all premium payments, then

that's a little different message than if it's medical care costs.

MS. XANTHOPOULOS: They had higher than average premium spending, but it wasn't driven by -- at least in the panel. But I ranked them in the first year and then preserved that ranking throughout to watch them. But they did have higher than average premium spending, but that wasn't what was driving --

DR. KEMPER: That wasn't what was driving it?

MS. XANTHOPOULOS: No.

DR. KEMPER: So I think that some of these messages could get across of this whole set of updating issues without coming out and making recommendations.

DR. WILENSKY: I don't know how many of you recall that in the 1980s there was a proposal to have a budget neutral rearrangement of the benefits prior to the catastrophic legislation in 1987, that would basically put back end coverage in place. I think it was around 1983 or 1984.

This is to echo the notion that this is part of a much larger picture. You could conceivably propose having

stop loss insurance, which is what this is all about, in a budget neutral way by rearranging the Medicare benefit package. I think taking on issues like this, outside of that context, given the other fiscal issues, becomes more difficult.

MR. SHEA: Gail, can I just a comment on that? It seems to me that there is clearly separable categories here, in terms of sort of appropriate issues for this group to address. And just as we talked about the issue of the beneficiary costs on the outpatient side because of the problem in the formula, where I think we didn't have any disagreement about the appropriateness of addressing that, I think in this case we're not going as far as we should add prescription drugs, which I think clearly would cross the line and might cause some upset around town.

In this case, we're raising a problem with the existing structure that clearly is the result of -- I mean, these are conversations we've had about liability that have gone on for some time. Now maybe there wouldn't be a consensus here in support of my position that we ought to seriously consider this. But I'd hope at least that we'd

have an analysis here that raises this issue.

And in that respect, I like the comment that you made, Peter, about a little bit more elucidation about sort of what are the general themes. You do get a little lost in the weeds here of some of the numbers.

DR. WILENSKY: As I just suggested, I have no problem supporting a budget neutral rearrangement that put a limit on expenditures. But again, I'm not sure at this point that's a significant step that this Commission may not choose to take.

It's why this issue of within what context because you could propose such a rearrangement of insurance that would not increase the cost of Medicare spending but put a limit on it.

MR. SHEA: I guess the point I'm trying to make is that --

DR. WILENSKY: But I don't disagree with what you just said, in terms of the information that we ought to have available in the discussions about what the present structure means in terms of liability --

MR. SHEA: I want to go a little bit further. I

think just as our responsibility is to do a lot of the payment stuff and the quality issues that we were talking about earlier, and all the important issues for beneficiaries, this is just a very important issue. And for us not to put out an analysis of this and address it -- I'm not talking about what we propose now, but sort of approaching the subject -- I think would be sort of walking away from it.

And sure, some people would say we ought not to tackle this at all.

DR. WILENSKY: I agree with you.

MR. MacBAIN: I'm not sure that when you rearrange benefits you end up with something that, in practice, really is budget neutral. In the case of a cap, for instance, those 15 percent who are now exposed, some of them may go well beyond the level where this cap is and those additional costs are borne by providers in the terms of bad debt or uncompensated care. And now we recapture that as Medicare expenses.

So I'm a little cautious. It may look good on paper but behavior has a way of fuzzing that up.

I do think that this chapter hits on some very important issues, though. Without trying to solve the problems at this point, I disagree a little bit with Judy. I think this probably is a good group of people to deal with it, even if it's outside of our purview as a Commission.

But without trying to do that right now, I think that it would be appropriate for us to put the information on out-of-pocket expenses, both covered and uncovered, out in very stark black-and-white terms. This is where this benefit program is now, given 1999, 2000 reality of health care costs versus 1960's benefit design.

DR. NEWHOUSE: First, I very much like the analysis and I'm pleased it will be part of the June report.

I was actually going to make the point Gerry made about the outpatient department coinsurance rate but I am prepared to accede to the judgment that the Congress isn't interested in hearing a recommendation from us on this point, at this point in time.

But certainly, the chapter ought to be part of our report.

DR. LAVE: Let me be perfectly clear, I have lots

of recommendations that I would like to make on how to restructure the benefit design. But I do have a couple of suggestions. I like this chapter a lot. I think it's extraordinarily important and I think it's also very critical about how we define it.

I would like actually, for the introductory paragraph, to talk about a little bit what do you mean by insurance program? What should we be insuring against? How has this program been designed? And is it designed to be an insurance that protects you against the things that ought not to be there?

So you have some sort of a context in which, in fact, you're looking at this. And then, it seems to me, you may also want to, as part of this which has been done before, is to look and say the Medicare program as an insurance program -- how am I doing, Gerry?

Is really very different from the nature of even the indemnity based insurance programs that exist in the private sector. Most of the ones that I'm aware of, they have a single deductible. They have a set of copayments, and they are subject to a catastrophic cap. I mean, all the

ones that I know of have those characteristics.

So you have a theory of insurance that sort of tells you what you ought to be thinking about. You have a whole set of indemnity-based out there which have very different implications about how the risk is portrayed. Then it seems to me that one has a section that basically indicates that by and large that the Medicare beneficiaries have not been willing to expose themselves to this risk. And then you talk a little bit about the supplemental policies. And then you say let's look at what the implications are of the current arrangements and looking at both the Medicare and the overall services.

That then, I think, leads you to where you want to go. But I think that that has a structure on it that allows you to put it in context, put you in context with what the debates are about how insurance should be covered. It puts you in context with the range of covered services.

My sense is that the Medicare range of covered services, with the exception of drugs, is probably better than most private sector ones, excepting drug and vision. But the Medicare population is the population that really is

at risk for long-term care type services.

So I don't know, we may want to look at benefits covered. But I want to put it in a context rather than -- I mean, my context would be what's the standard, one way to look at it.

DR. WILENSKY: I agree that I think having the front part address this issue of theory of insurance or a discussion, would make the rest of it more meaningful.

Bill, do you have a comment to make? Then I think, assuming that we're not going to have this recommendation, we need to move to Beth's chapter, which is a lot of recommendations. And we'll have an opportunity to see another crack at this next month.

DR. CURRERI: I just really have a question. I'm looking at figure two that was in your handout. As I look at that from the less than 10 percent to the 90 to 100 percent range, the increase in expenses is all in this group called medical provider. In other words, everything else stays relative stable or increases a little.

So what's included in medical provider? I don't understand why that's the driving force.

DR. NEWHOUSE: Because there's no back-in coinsurance on Part B.

DR. CURRERI: So does that mean that everything out here on 90 to 100 percent are people without --

MR. ZABINSKI: No. Here's what I would say is going on here in the top end with the medical providers. I would say it's partially due to what Joe just said, that there's no limit on the Part B services. For example, when you get into this top group and you look at the Medicare only people, their average medical provider is about $3,700. Those are those people in that top group.

The other insurance categories, like Medigap --

DR. CURRERI: So these are people without supplemental?

MR. ZABINSKI: That's right.

DR. CURRERI: So they make up the majority of this group?

MR. ZABINSKI: No, that's not quite right, either.

DR. NEWHOUSE: No, because there's some supplemental premiums there, too.

DR. CURRERI: The premiums are in a different

block, Joe.

DR. NEWHOUSE: But they're non-zero, Bill, in that group.

MR. ZABINSKI: The other insurance types are pretty much below the average. When you take out the Medicare only people, the medical provider average in that top group drops by about $240. So they're having a sway in what's happening there.

I think another issue there also is non-covered services. As you move from each of these groups, the expenditures on non-covered services also increases by a fair amount.

DR. NEWHOUSE: But you've got drugs separately accounted for.

MR. ZABINSKI: But also on medical providers there's use of non-covered services within the medical provider group, too.

DR. NEWHOUSE: Are you talking about chiropractors or what?

MR. ZABINSKI: I'm not quite sure.

DR. NEWHOUSE: What is the non-covered service

we're talking about?

DR. CURRERI: I think my point here is that since that looks to me like the big driving force that increases out-of-pocket expenses, it might be worth our while to categorize that area specifically and look to see if there aren't small corrections that could be made in that area that would decrease this enormous increase. Because it clearly is related to that one category.

MR. SHEA: There's a footnote on page three, by the way, which defines what's included in that category.

MR. ZABINSKI: It's also at the bottom of the diagram, in the notes, where it says medical provider category includes spending on physicians and other practitioners, diagnostic, laboratory, radiology services, medical and surgical devices, durable medical equipment and non-durable supplies.

So basically you sum it up, it's sort of like Part B services.

DR. CURRERI: For instance, let's say it's all due to increase in durable medical equipment and non-durable supplies. Just take that as an example. That might be a

single area that we could look at.

MR. ZABINSKI: I'm not sure. Here's one problem with trying to do that with the MCBS, is that -- yes, we could probably try doing it with the claims file. That's true.

DR. WILENSKY: Yes, because I think the accuracy in the MCBS is questionable.

MR. ZABINSKI: In the MCBS about half the reported encounters are very accurate, in terms of what provider was visited. But then the other half they have no record at all.

DR. WILENSKY: In the claims data we can look for the covered service and that would either tell you or not. If it's not there, then you're looking at uncovered items. That also tells you something.

DR. NEWHOUSE: Can I also suggest you put in the decedents? I think you might get -- I think they're disproportionately in this top group. Could you put in the decedents?

MR. ZABINSKI: No, they're not in this.

DR. NEWHOUSE: I know they're not in here. I'm

suggesting you put them in.

DR. ROWE: Say please.

DR. NEWHOUSE: Please.

MR. MacBAIN: If we identify something in here, let's say that it's all durable medical equipment so we're able to deal with that. What we would do is we could change the scale on the left. We might bring those numbers down, but we wouldn't change the shape of the graphs much at all, because by definition the people in the top decile are going to be the ones that are spending a lot in these very areas.

DR. CURRERI: But you could reduce the range or the scale, as you call it.

DR. WILENSKY: Thank you. Beth?

MS. DOCTEUR: You've had some excellent focused discussions in this meeting of some very specific Medicare quality issues. This paper asks you to step way back and to look at the question of the systems of care that we use to assure quality under traditional Medicare.

There are two general themes that seem to emerge from the draft chapter. One is the need for consistency and coordination with best practices in the private sector. The

other is consistency and coordination across the Medicare program as a whole.

I'm going to propose that you not go through this chapter and try to highlight the key issues, because I think it's a very dense chapter and I really need to get feedback from you at this point. So with apologies to the public, if that's acceptable to you, I'd just put up the slide that has the seven major quality policy issues that this chapter tries to provide a framework for thinking about.

And those seven questions are basically relating to objectives. What should Medicare's objectives for quality assurance and improvement under traditional fee-for-service Medicare be? What role should the program adopt in trying to help it meet those objectives? Are the existing tools for assessing quality adequate for Medicare's needs? In which quality improvement and quality assurance strategies ought Medicare employ those tools? Who is accountable for quality under fee-for-service arrangements and what mechanisms are available to Medicare to hold those parties responsible?

What about incentives? To what extent should

Medicare rely on penalties versus rewards in its accountability mechanisms? And finally oversight. Should Medicare use existing private sector oversight mechanisms more fully in its quality assurance programs?

I'll turn to you.

DR. ROWE: The less you say, the less we'll say, is that the idea?

MS. DOCTEUR: I'm happy to go through the chapter's issues, but I thought it was an extensive --

DR. ROWE: How do you want us to do this?

DR. WILENSKY: Why don't we go to the recommendations. Let me just ask if there are any questions that people want to raise in general, that's fine. Then I think we ought to go to the recommendations.

DR. LAVE: I had a structural issue here that concerned me a lot. I think it would help me in thinking about this. And that's the following issue. It had to do with the statement that we should implement quality assurance and improvement systems that are consistent, comparable and coordinated across all sectors of the Medicare program, including fee-for-service medicine.

My concern is the following, and that is that it seems to me that to some extent that the quality initiatives are focused on different entities. And it's not obvious to me that the way that one goes about some of these things, in fact, can be comparable across the entities. I don't know the extent to which, in fact, if one thinks about a plan and what one expects of a plan which is responsible for maintaining the health of the population, as opposed to the sorts of initiatives that may take place that would influence a physician, a hospital, which are more like some of the fee-for-service ones.

And I think it would have been very helpful up front if one had thought a little bit about the nature of quality assurance programs in the different kinds of systems that you were trying to impact because the levers are different if one is focused on a plan or if one is focused on a hospital.

And I found that that was missing, and so I found that I was reacting sometimes to things which I wasn't sure whether they could be consistent or whether that was really even the right way to start off. So I would have liked to

have seen some sort of a framework for us to think about quality problems in the context of plans.

I mean, clearly, the plans negotiate with hospitals and they would want the hospitals to be just as good as the fee-for-service system. That would have been very helpful to me because I struggled with that issue as I went through it.

DR. CURRERI: It's particularly apropos, I think, when you get out to offices where they're very difficult to monitor, and patients' homes, which I think is even more difficult to deal with, in terms of quality.

DR. ROWE: Is our mandate here to address the process, organization and system with respect to quality assurance and monitoring? Or is it to address the content of what is used to improve quality?

DR. WILENSKY: Both. They're both appropriate.

DR. ROWE: Because this is more the former than the latter. There seems to me to be a relative dearth or neglect or certainly less emphasis -- there's a lot of material here, but there was less emphasis on what we would consider to be important.

For instance, issues with respect to health promotion and disease prevention. Do we think that the presence or absence of that tells us anything about the quality of a Medicare+Choice program? You know. Do we think that Medicare+Choice programs that have a lot of health promotion and disease prevention, is that something that we would say would be better rather than worse?

So should we say something about that? In other words, there are some elements of content as well as process and system that we might consider.

MS. DOCTEUR: This draft chapter definitely focuses just on the process and systems. And with respect to prioritizing various health care quality concerns, it only talks about it in the sense that it recommends that Medicare develop a public process for trying to define those.

DR. ROWE: That's right and you say that. And your recommendations say from time to time we should go back and make sure it's up to date and test it with a field and all that, in recommendations two and three and four. I buy all that, it's just that I just wondered whether it would be

appropriate for us also to make some recommendations with respect to --

DR. WILENSKY: The question will be, as we go through the recommendations, and I think we'll do better to answer this question to go through the recommendation, is to the extent that we have recommendations to make about the content, it would be useful to do that. We may or may not be in a position to do it for this year.

DR. NEWHOUSE: I had some of the same concerns Judy did. In particular, we said we wanted, in recommendation one, we wanted systems that were consistent, comparable and coordinated across all sectors. And then in four, we said we wanted to find sets of quality and performance measures for each sector.

So that wording seemed inconsistent to me, although maybe it isn't.

DR. ROSS: Can I respond to that? If I mispeak, Beth will correct me. I view recommendation one as much a statement of principle as a statement of specific issues.

DR. NEWHOUSE: I would suggest rewording this one.

DR. ROSS: It's directly in response to

expressions by the Commissioners back in November that we focused a lot on quality on the risk side, why aren't we focusing on fee-for-service? The issue here is a level playing field and I think the key word in here is comparable.

DR. NEWHOUSE: Oh, that's what you mean by sectors? See, I interpreted sectors to mean the hospital, the office, and it sounded like Bill Curreri and Judy did, too.

MS. DOCTEUR: There's a lot of terms that are used in here. In the first recommendation, by quality assurance and improvement systems what I was trying to get at is the big picture systems. Do we have a system of public reporting of information on quality? Do we have a system of focused quality improvement programs? Do we have a system of holding organizations or providers accountable for performance?

So those are the components of a quality assurance and improvement system, as I tried to use the language here.

DR. NEWHOUSE: Let me mention a concern that doesn't, I think, surface enough in the chapter. It's a

concern, I think, with both sectors. It's what I'll call the hand-offs. That is, the patient that's moving from one setting to another. The quality measures in fee-for-service that I know are typically oriented within one institutions walls or one office or whatever. Discharge planning is notoriously a problem but it's not clear how one would go about measuring that? Or is it?

We ought to say something about that range of issues.

DR. ROWE: Now we're into content.

DR. NEWHOUSE: But when we get to recommendation four, when we say for each sector, I think the implication is we mean kind of within sectors, as opposed to between sectors.

MS. DOCTEUR: Perhaps better language might be to say across all sectors and where --

DR. NEWHOUSE: No, I don't think that's sufficient. A text discussion can carry the point.

DR. ROWE: Within and between or something.

DR. LAVE: I want to come back -- when I read this first one I wasn't terribly sure what it meant but I do

think that there are some differences in the types of systems that you may want to apply to different sectors. And when you read this, it sort of sounds as if you're -- it almost sounds to me as if you were trying to put everybody in the same box.

DR. NEWHOUSE: So let me suggest a wording change which is that after -- you just insert a few words, quality assurance and improvement systems that are, to a greater degree than at present, exist in comparable --

DR. WILENSKY: Or to the extent possible, the kind of language that we used in PPRC.

DR. NEWHOUSE: Not just possible. You ought to have an element of desirable, too. You might want to do everything that's possible.

DR. ROWE: I think what we want to avoid is a sense that we're trying to reach homogeneity or density. Two things can be the same quality but not identical. One can be left-handed and the other right-handed.

What we want to do is we want to establish a standard of care, a standard of quality, and a way to monitor it, measure it, improve it. But we don't want to

try to tear out of the health care system the traditions and the specificity and the feel that each institution has or doctor, or way each health plan or physician group has of doing things.

So some of this sounds a little bit, Beth, as if it's big brother government establishing a standardized way.

DR. CURRERI: I'm even more concerned about the potential resources to do this. I mean, look how many homes you have, as compared to how many hospitals you have, as compared to how many -- when you get to doctor's hospitals, we're talking about a half a million offices. When we get to individual homes we're talking what, 64 million?

So you obviously are going to have to have different quality systems, particularly when you go across different sites. And to suggest that we can do it all in one way -- now I think in principle what you say, and somebody suggested that, it's okay to say that. I don't know about the word consistent. Comparable, I think, is fine because they could be different but comparable depending on the resources available to do this.

And they can be coordinated. I'm a little

concerned about consistent because to me consistent means we're trying to make this all one homogeneous system that we're going to evaluate in the same way.

MR. SHEA: Can I just, on this point? These are words that are -- you'll get a few words and they wont' be perfect. But just on the consistency issue, one of the big complaints I hear in quality discussions among private purchasers that they hear from providers on the hospital side is would you please give us one system? In drugs could there be a formulary, as opposed to everybody having a different formulary because they cut a little special deal.

And it goes somewhat to your point, too, Jack. Somebody's big brother might be somebody else's organizer of the process. I think we need a strong player in this, just looking at it from the private purchaser point of view. And so far, Medicare has not stepped up to the plate on this issue. And a lot of resources have been put into this from the purchaser side on what can we do to quality measure? How can we make them useful to people?

If Medicare kind of hangs back on this and doesn't say we're the biggest purchaser, we're going to play an

appropriate role in this, I just don't think we'll ever get to where we could be here.

DR. CURRERI: I don't disagree with the word consistent if you limit it to institutions that are the same. I mean, you can be consistent across all hospitals, as far as I'm concerned. Or all plans as far as I'm concerned. But I don't think you can be consistent and then try to spread yourself off to offices and homes and nursing homes and this sort of thing, because it becomes a task that's impossible.

DR. NEWHOUSE: This isn't on the recommendations but I'll give this to Beth. Several places in here I wrote a question mark in the margin about where did cost fit into this. This discussion goes on as if resources were not scarce in some places. Maybe that's Bill Curreri's point as well.

MS. DOCTEUR: There are cost factors on both sides of the equation, though. There's the cost to Medicare of improving its systems. There's the cost of inefficiency to the extent that current systems aren't coordinated and to the extent that that costs extra money.

But then, of course, there's the providers' costs and to the extent that there can be more coordination across the private sector, in the public sector they wouldn't have to respond to accreditor's standards and --

DR. NEWHOUSE: I agree with all that, but unless I missed it that wasn't in the chapter.

MS. DOCTEUR: Right, that's true.

MS. NEWPORT: I think it's an interesting debate because it's some of the same issues raised on the Medicare+Choice side that you all are raising, in terms of comparability of data and what's important to have. And the debate goes on.

As a matter of fact, over the last two days, Bill Thomas was pushing Jeff King very, very hard yesterday. He has data, quality measures, in terms of mammography rates, things like that, fairly simple measures. And he won't put them up on any web sites because he contends it's not an apples to apples. Which Bill Thomas responds back, that's all right. This is something that is at least a starting point.

And I think that I'm completely sympathetic with

all that's said because it's the same issues we've raised in terms of QSMC and the types of diversion from the paths that plans have already gone done one way, we're going another way. And I think it's very important to the dialogue to understand how complicated this is and look at maybe these as statements of principle because I think the recommendations are fairly broad.

But the other part of this is the really tough part, is getting the appropriate start to this, so it does have some meaning and it doesn't conflict with all the issues that you all have raised. It may be just fine that they're not necessarily comparable across every sector. But at least there are some measurements that are defined, cost effective measurements that are meaningful at some level.

MR. MacBAIN: This may be a bit of a throwback to yesterday's discussion but it was addressed in here at all I think it was sort of superficially in the context of hospitals, and that's the importance in protecting quality improvement information from discovery if it's going to be extended aggressively beyond the hospital setting. I think particularly in the area of physician's offices where the

only effective way I know to do this is to pool information across a number of offices. There's going to be some entity that is not the physician that is going to have sensitive data. If it isn't sensitive, it's not going to be of very much value.

Right now I don't know that state quality improvement legislation would protect that. It doesn't very often if the health plan holds it, for instance, and it could be equally true for a PRO or some other entity in this context.

DR. WILENSKY: Let me raise one issue that comes up later, since in part I'm not sure we're going to get through all these recommendation, you know go back and start with the first. I think there's some confusion with regard to the HCFA deeming process. When a private organization wants to get accredited to deem, it has to provide exceedingly detailed information about all of the steps it will go to, and what information it will require, and how it will proceed. And HCFA negotiates or sets the requirements at a very micro level as to what will go on in terms of deeming.

And it's only after -- this is how it was a decade ago, I assume it's still like that. It's a very detailed review procedure as to what steps the organization will steps. Then when deemed, it is not the agreement -- it is mainly an ability by HCFA to set the rules in some great detailed specification as to the process that will be used, and that turns somebody else loose so that they don't actually have to physically mount the effort to do the accreditation.

When I read that, it's possible that that is not the process that's being used now, but my guess is that the old process is in fact used, or at least used some of the time. But I think there's needs to be more work done to clarify what deeming means. It seemed it much more of, all right, you go do it and we'll give you sort of some general parameters. But that isn't what happens. It certainly isn't what happens in hospital accreditation and nursing home certification.

MS. DOCTEUR: I'll clarify that in the text.

DR. WILENSKY: Spence, and then let's go back to recommendation one.

MR. JOHNSON: This just goes back to preaching to the choir, I guess. But this whole section in terms of hospitals and the different type of quality thing. If anything, we have dueling quality activities going on out there. As Woody might know, in Michigan, patient satisfaction is the quality of diagnosis and treatment, is the quality of outcomes.

We have the joint commission on Medicare, Medicaid, public mandatory access to data at the state level. Blue Cross, within Blue Cross we have the autos auditing their Blue Cross activity. We're also going to work on Blue Cross on a geographic variation quality issue with Wennberg statewide. Various employer projects, like our southeast Michigan data project where we're cooperating. The issue like we talked about with liability yesterday in terms of, is it punitive quality or learning quality, through-put kind of quality.

So my only point here is Medicare is sort of late to the dance on this one. At least on the acute care side, the train has not only left the station but is halfway across the country. It doesn't mean that it's all right,

but it means there are a lot of things already in place. And I don't know how we handle that aspect of it, because within each state there's a lot of activities going on.

DR. WILENSKY: Let me make a suggestion at this point that the need and desirability to coordinate the quality improvement strategies, without getting into specifically how Medicare ought to relate to the private sector -- I mean, I think there's probably widespread agreement that it needs to be better coordinated. But whether it ought to be Medicare and everybody else has to follow suit, or whether it's some kind of coordinated process of a public-private partnership, I'm just not sure that we're really the group.

I know the forum that followed -- Jim Tallon's involved with it -- followed from the Commission is trying to work on that effort. But I think we certainly ought to raise the point that it is costly and inefficient to have --

MR. JOHNSON: Yes, and the problems hospitals find themselves in is like trying to build a big fire to push back the night. This is just going to be one more log on a blazing fire.

DR. WILENSKY: But it is hard to not have the Medicare, as a $200 billion program, 85 percent of which is in traditional Medicare, cannot walk away from this.

MR. JOHNSON: I agree.

DR. WILENSKY: I mean, that's a whole lot more money than most of the other players.

MR. JOHNSON: I don't disagree with that. It's just the sensitivity --

DR. WILENSKY: If you're going to have public discussion -- I mean, we can have you give your private comments. But if we're going to get any public discussion, let's get a move on and look at recommendation two. I think we gave Beth the sense on recommendation one of what we'd like to see about comparable --

Any comments on recommendation two?

It looked like a pretty good --

DR. ROWE: Is this where we get to content?

MS. DOCTEUR: Yes.

DR. ROWE: This is as close to content that we get, right? Define prioritize set of goals.

DR. WILENSKY: Is there anything that you might be

able to do in between our next meeting working with Beth or suggesting what she might want to --

DR. ROWE: I don't want to push my particular hobby horse, but I think what we might do, since this is a little vague, is that it might not be unreasonable to include a paragraph in the narrative, and maybe a half-sentence in this as an example. For instance, you know. So if we have one or two for instances, people would say, oh, now I understand what they mean.

DR. NEWHOUSE: Do you have one or two in mind?

DR. ROWE: Yes, I would think we could pick -- I have my favorite on health promotion in Medicare+Choice plans, and we could pick something out of HEDIS or something that looks -- for instance, so they know, oh, here they're worrying about the content.

DR. LAVE: And in Medicare fee-for-service, do you have a --

DR. ROWE: Yes, I'll come up with a couple, sure. I mean, vaccination rates. I mean, use of influenza vaccines. That's a quality measure in old people, let's face it. It's there. It's paid for. And if people aren't

getting it, disproportionately not getting it in one hospital or one practitioner's practice, I think that's a quality issue. So that would be a fee-for-service, traditional Medicare. Something like that.

MS. DOCTEUR: I can easily come up with, for examples.

DR. NEWHOUSE: There's a problem linking traditional Medicare to one practitioner.

DR. ROWE: But these are the kinds of things that at least get people some focus on what the content might be.

MS. DOCTEUR: I can easily come up with some, for examples, if you want to actually make recommendations about what the priorities should be.

DR. ROWE: Call me and we'll talk about it.

DR. WILENSKY: Okay.

DR. NEWHOUSE: The third recommendation?

DR. WILENSKY: It's hard to argue against best practices.

Fourth recommendation?

DR. NEWHOUSE: Maybe we should see if there's problems with any of these just sort of en bloc.

DR. ROWE: Isn't this already included either in number one or in number two?

MS. DOCTEUR: Number one deals with quality assurance and improvement systems saying that, for example, the components of the quality assurance systems --

DR. ROWE: I understand. How is number four different?

MS. DOCTEUR: Number four deals with quality measures. Measures of immunization rates, for example, measures of care for the dying.

DR. ROWE: Why don't we include them -- I mean, maybe that really gets to my question about content. Why don't we include them both in one and make the point that the Secretary should be involved in, both, to define set of quality and performance measures, and secondly, quality assurance and improvement systems? And put them both in one, and that way we're looking at both sides. Then we can say all these words about all these other people that they have to deal with, because that's all relevant for both of them.

MR. SHEA: I'm not sure that they're actually

parallel situations. Because I took four to be the coordinate with the rest of the world.

MS. DOCTEUR: Yes.

MR. SHEA: And I took one to be, make sure you're doing it in your own house.

MS. DOCTEUR: Coordinate within Medicare, yes.

DR. WILENSKY: Yes, that's what I thought.

MS. DOCTEUR: Yes, that's how I see it.

MR. SHEA: Maybe you could combine them, but --

MS. DOCTEUR: One being, have systems coordinated across Medicare; four being, have quality measures that are developed in conjunction with what the private sector is measuring. That makes sense.

MR. SHEA: And not your own set that doesn't match the --

MS. DOCTEUR: Exactly.

MR. JOHNSON: Just one comment to escalate the word game. I'll probably be shot for this, but thinking of the joint commission and the role in the process, could we use a word like partner? Because if there's already some criteria and process out there, maybe if someone like the

joint commission and HCFA got together on the aspects of the institutions they're licensing, maybe at least it wouldn't just be throwing one more log on the fire. We could somehow get them to partner and get them to come up with something.

DR. ROSS: I think our editors would kick partner.

DR. WILENSKY: Yes.

MR. JOHNSON: Really?

DR. KEMPER: Is that a verb?

MS. DOCTEUR: Should form partnerships with?

DR. WILENSKY: I'm just not sure --

MR. JOHNSON: Joint venture?

DR. LEWERS: Merge.

DR. WILENSKY: I'm not sure it is appropriate to ask a $200 billion player to partner.

MR. SHEA: Also in some cases there are very clear structural relationships that aren't partnerships, the joint commission being a good example. I think the notion of sort of, make sure you don't do something different. Don't go up and reinvent the wheel, is the right notion. I thought, Gail, your --

I think there's consensus, by the way, among the

sort of purchasers of high quality characters about there is not --

DR. WILENSKY: I agree.

MR. SHEA: -- this ought not to be a HCFA-run operation in order to be --

DR. WILENSKY: Right. No, I quite agree.

MR. SHEA: You know, build on what's already been done out there by people who have done it. So I think that's the direction we're heading in. But I just think we need to be a little bit careful about the --

DR. ROWE: Why don't we do it this way? We have the words consistent, comparable, and coordinated in this first one. That's really what you're talking about. You want them consistent, comparable, and coordinated across these different agencies or entities that might be working in the area. Beth was talking in that about across the different sectors of the Medicare program. But we might be able to develop some language using those terms that ties those --

MR. SHEA: I think you could shorten this.

DR. WILENSKY: Yes, I think draft recommendation

four is pretty good.

DR. ROWE: You don't think it's too long, too many words?

MR. SHEA: Maybe, but it's late.

DR. WILENSKY: We're not paying by the word.

DR. LEWERS: You'll have another shot at it, Jack.

DR. MYERS: As a result of the President's Quality Commission I think there were two entities that were formed after that, one of which was dedicated to what it sounds like we're asking for in number four. Is that entity still alive and working?

MS. DOCTEUR: We'll know later this month. What's going on right now is the forum planning committee being headed up by Jim Tallon, and they're working on trying to find funding mechanisms and defining mission statements for this entity that's going to -- if it comes about, will be known as the Forum for Quality Measurement and Reporting. It's still an unknown, but it's envisioned that Medicare would play a role in this. So this would be supporting that, presuming it does come about.

MR. SHEA: If HCFA's been supporting --

DR. WILENSKY: I don't think we want to give it away yet.

DR. LEWERS: No, don't.

DR. WILENSKY: I mean, this may be the mechanism. I've talked to Jim Tallon twice about it. But I don't -- I mean, let's wait and see if it's birthed, and survives a year, and make sure it's functioning in a way that we would want to delegate some significant authority.

I mean, I don't mind having somebody come up with a shorter version of four, but I think that four actually says what we're talking about.

DR. ROWE: What we want to say. Okay.

DR. WILENSKY: I had an issue I think on six. I don't know if anyone has on five. Bill?

MR. MacBAIN: I started out kind of liking that and the more I thought about it, the more nervous I got with it. The notion of the default Medicare plan in -- assuming we end up with a real Medicare+Choice marketplace -- of the default plan itself behaving like a PPO concerns me. And that is, there should be a fee-for-service plan available that is in any one provider plan.

Eliminating that puts us back with the discomfort with conditions of participation. That is HCFA on behalf of the Medicare program is selectively contracting, those that they select out may be out of business. And that is not, at that point necessarily a way to improve quality, unless somebody is really egregiously bad.

It's not a positive incentive, and it could be an extremely heavy negative incentive. Also, pursued aggressively, really would eliminate the option of a straight fee-for-service alternative as one insurance option, which I think belongs in the portfolio available to beneficiaries.

DR. WILENSKY: I guess I didn't -- when I read this I thought that five was implementing an issue that Jeffords and others at the Labor Committee had raised last year about trying to actually come up with strategies that differentiate Medicare payment with regard to quality measures. So I think that having the demonstration authority to do that seems -- I thought that was reasonable. I think having clarifying language about what we don't mean here --

MR. MacBAIN: Yes, if it says pay for quality. That if we have objective measures of quality we won't improve your payment rate, or if you fall below it, we're not going to pay you as much, makes some sense to me, although I'd want to look at it in more detail. But I've done a superficial, although it sounds reasonable.

But I'm more concerned about selective contracting and PPO contracting in the sense that people could be excluded from the network in a way that could put them out of business.

DR. ROWE: If they were low quality.

MR. MacBAIN: Or if they failed to achieve certain things that may or may not -- given the lack of precision in measuring quality, particularly in an individual physician's practice, or even in a hospital. You could be extremely good -- you could be the best hospital in town, but if you failed to achieve a quality improvement standard one year to the next you might fall below the mark. So selective contracting is a little draconian for a huge benefit plan at the default level, the straight fee-for-service level.

DR. WILENSKY: And you don't want to have

demonstration authority? I mean, I think politically -- I've said this in the past. I think politically, the notion that HCFA is going to ever get selective contracting authority is simply wrong, because the politics aren't there. I mean, if you would rather just delete the selective contracting and have payment incentives in there, that would be all right, since I think it's a political non-starter.

MR. MacBAIN: Yes, that's a little more --

DR. ROWE: I think it makes sense.

DR. KEMPER: I just had a minor comment that those two recommendations seem to be pretty closely related and might be combined. Just given the late hour, I just want to raise an issue for a future discussion. That is, it's come up in a number of chapters that there's a style of sort of text recommendation, text recommendation, and that seems to me to proliferate recommendations, which I'm not necessarily against. But I just think it's something to think about that we get long lists of recommendations and may lose punches as a result of that. But let's talk about that another time.

In this particular case, I just thought these were so closely related that they --

DR. WILENSKY: I think that if we have -- I personally like the style of having a summary sheet that lists all the recommendations, because it becomes very clear. Then having recommendation text, recommendation text, so you elucidate what was in there. But it becomes very clear when you see it on a cover sheet.

DR. KEMPER: The list is fine. That's fine. It's just sort of being compelled to always have another recommendation was the issue.

DR. WILENSKY: On six, when you talk about the demonstration authority, I think the Balanced Budget Act, at least in some of this, so I think we need to be careful about what they are already either instructed to do or doing. I know with regard to disease management there was instruction to -- there was a mandate to HCFA to do that. So I think we need to be a little careful --

MS. DOCTEUR: I missed that. I'll go back and check.

DR. WILENSKY: -- about what they are already

instructed to do, but probably not doing, so there's not much point in asking for new authority.

On seven, any comment?

DR. KEMPER: Does facilities and practitioners include surgicenters and SNFs and physician groups?

DR. NEWHOUSE: Yes.

DR. WILENSKY: I would think so.

DR. NEWHOUSE: It should.

DR. KEMPER: Then I don't have a problem.

DR. WILENSKY: Eight? It seemed to me that eight belonged -- I mean, it was part of, it's an extension of this issue of developing ways to pay for quality. So I would have this somehow structured that --

MS. DOCTEUR: Conceivably, it could be other things besides payment incentives, perhaps designating providers and report cards that had --

DR. NEWHOUSE: You should make that clear.

DR. WILENSKY: I did not understand that. And you may want to --

DR. ROWE: Perhaps what?

MS. DOCTEUR: Just off the top of my head, in

provider report cards, designating which ones had consistently exceeded the quality measures.

DR. WILENSKY: You also may want to -- you ought to put them, I would think, spatially contiguous.

MS. DOCTEUR: Okay. Or they could be perhaps exempt from having to -- perhaps they'd only have to go through a review cycle every three years instead of every one year, for example?

DR. ROWE: I'm thinking about Bill MacBain's about the region -- if there's nobody in a region who is on the report card list of the good guys or something and so --

DR. WILENSKY: I don't know, I'm not sure that that --

DR. ROWE: Maybe that's all right.

DR. NEWHOUSE: That's different from decertifying.

DR. WILENSKY: Yes. The draft, the ninth recommendation. I don't think that you ought to direct HCFA to use private accreditation. I think that you certainly -- they ought to be -- I don't think they need any more authority to use deeming, but I don't think they ought to turn that over. I do think the coordination is very

important, but I don't think they ought to turn it over.

We gave somewhat short shrift to the specific lines in here. If people have comments, give your chapters to Beth, or get them to her during this period.

DR. ROSS: Could I make one note for the remaining commissioners? I'll send an e-mail to -- but again, a reminder, because of the schedule for the April meeting and the production date, that we will be sending drafts out for review both to you and to others. That we'll have the revised draft recommendation, just so we're aware that next time you see it that others will be seeing it outside the Commission.

DR. WILENSKY: Public comment?

MR. CASEY: My name is Don Casey from the Maryland Medicare Peer Review Organization. I just want to make some additional comments. First of all, I wanted to point out that the partnering that was referred to in the discussion I believe is already ongoing in certain informal ways, at least on the hospital side. But I will make my comments relative to both the fee-for-service and other arenas of health care.

Right now I think -- there was a slide in the presentation that I appreciate, and that is the limited data on best strategies for influencing quality is a problem. In fact, I think it's become an issue of not what to do, but how to do it. I would suggest that there's an opportunity here to borrow some wisdom from scientific marketing methods that would develop approaches related to information and behavioral diffusion models of adoption.

There tends to be a normative belief that one size fits all with respect to quality improvement activities. And anyone who's done QI at the shop level understands very clearly that one size does not fit all.

There was some mention yesterday about -- well, it's no longer an issue of what to do or even how to do it, but rather what to do first. There are enormous priority-making decisions that exist in all organizations with respect to quality. It seems as though we would be informed by a conjoint analysis of financial and non-financial performance measurement activities.

Just to talk about the quality improvement organizations. There was a reference to the fact that we

don't focus on errors, but if you define errors in terms of commission versus omission, in fact we do focus on errors of omission. An example would be not providing aspirin therapy to patients who should get them, having suffered a myocardial infarction.

The next scope of work, as you may know, focuses first on processes that are incontrovertibly linked to reduction -- activities that relate to reduction in mortality. These processes are often times, they find themselves buried in care plans, and hence tend to lose their primary focus, and that's a problem.

There also seems to be a golden opportunity to align provider-based information systems to capture key data elements necessary for accurate and consistent construction of performance measurement. I didn't see much reference to this issue, but I do think it's extremely relevant. I think that involving the suppliers and developers of health information technology would be a useful activity. And as we all know, claims data tend to be highly inefficient with respect to a performance measurement.

The last thing I'll just say as a quality

improvement practitioner is that the guiding principles of deeming, at the top of the list the three words, drive out fear, really head the entire quality improvement methodology, and that that sometimes creates difficulties for us.

Thanks.

DR. WILENSKY: Any other comments?

Thank you all.

MR. SHEA: Can I just -- maybe this all went on yesterday when I wasn't here. I just wanted to compliment the staff on the quality of the report that was issued, and compliment you, Gail, on the issuance and the reception that it got and the testimony. I thought it was all really top rate.

DR. WILENSKY: Thank you.

MR. SHEA: I find it remarkably readable material, based on the discussions that we've had. So good to have --

DR. WILENSKY: It's amazing what they do with our discussions.

Thank you, I agree and share those comments and sentiments.

We will be meeting April 29th and 30th at this hotel. It will be again a full meeting because it will be our last meeting before our June 1st report, so there is a lot to do and a lot to read. Thank you all.

[Whereupon, at 3:05 p.m., the meeting was adjourned.]