MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

**Thursday, April 24, 2003**
**9:40 a.m.***

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

*** April 25th proceedings begin on page 288.**

**NOTE: April 25th proceedings begin on page 288.**

P R O C E E D I N G S

MR. HACKBARTH: This morning we have a series of presentations that will be followed by commission votes.

The first topic on the agenda is the use of market competition in fee-for-service Medicare. Let me welcome all of our guests. We appreciate your joining us.

Anne, Sharon, proceed whenever you're ready.

MS. MUTTI: At Tab B in your background material is a draft chapter entitled Use of Market Competition in Fee-for-service Medicare. It follows the online that we discussed at the last meeting, laying out the design issues that must be addressed and competitive pricing approaches for fee-for-service goods and services, and discussing the experience of two Medicare competitive pricing demonstrations.

In this presentation, though, we will focus on describing the results of the two demonstrations and presenting possible recommendations for you to discuss. I will briefly discuss the results from the participating heart bypass center demonstration and then turn it over to Sharon who will discuss the competitive bidding for DME demonstration.

Also, for the benefit of the audience, we have reordered the slides, so they will be a little different but

they are all the same slides.

As we discussed at the last meeting, the Medicare participating heart bypass center demonstration was conducted between 1991 and 1996. The demo invited hospitals performing bypass surgery to offer a discounted price for all hospital and physician services bundled together -- that includes consulting physicians, as well -- surrounding two heart bypass DRGs.

CMS restarted the demonstrations to include more sights and more procedures, cardiac and orthopedic, back in 1998 and it was under a new name, the centers of excellence demonstration. Although there was considerable interest at the time among hospitals, Y2K and BBA priorities required postponement.

It was later relaunched again in 2000, focusing on three states. And while there was some interest in participation the discounts were not as great as they had been previously and ultimately, through the course of negotiations, interest waned on the part of the applicants. They cited concerns about reductions in physician payment and some hospital reclassification issues. So it is now not in operation.

But just quickly to go over the results of that

demonstration, it did produce Medicare savings of about $42.3 million and this is about 10 percent off the expected spending on bypass patients at those facilities. Participating sites were largely successful in reducing internal costs per episode. Three of the four original sites reduced costs between two and 22 percent between 1990 and 1993, depending on the DRG and the hospital.

Because the hospitals were able to bundle, they received the bundled payment and that aligned incentives between hospitals and physicians. And at the same time hospitals were adopting more information technologies that allowed them to track their costs to services. They were able to provide more incentives for physicians to change their practice patterns. And in so doing, they tended to reduce their ICU costs, their nursing, labs, and their pharmacy costs.

The three additional sites that were not subject to the same intense evaluation also appeared to have increased savings.

In terms of quality, the participating sites had lower mortality rates for these procedures than competitors, and that would be expected because that was the basis upon which they were selected. In addition, over the course of the

demonstration their mortality rates declined, as did the overall mortality rates at competitor hospitals as well, during this time period.

Market share was one area where the demonstration did not perform up to expectations. Only two of the seven sites increased market share. Four sites increased volume, but two of those lost market share concurrently.

In considering the possible reasons for this outcome, the evaluators noted that some of the sites, or most of the sites, did not aggressively market the designation. Also, also local market conditions were changing at the same time. Competitor hospitals were beginning to do bypass surgery in some of these markets. Others were opening catheterization centers.

They also noted that there was a general reluctance among beneficiaries and physicians to change their behavior, even if they were aware. And not that many individuals, not that many beneficiaries, were aware of the information. More physicians were but neither seemed to change their behavior very much.

So that concludes the summary of that demonstration and I'll turn it over to Sharon to talk about the DME.

MS. CHENG: The second demonstration that we'll talk about this morning is competitive bidding for durable medical equipment. This demonstration was mandated in the BBA in 1997, and in that legislation the Secretary was given the authority to test competitive bidding in up to five sites.

The legislation also gave the Secretary the authority, under the demonstration, to limit the number of winners of contracts to the number sufficient to meet demand.

The bidding began in this demonstration in 1999 and the demonstration was completed, according to the legislation, at the end of December, 2002. The demonstration was conducted in two sites, Polk County, Florida and San Antonio, Texas.

Between the two sites, there were three rounds of bidding for eight categories of durable medical equipment. The products ranged from those simple commodities that could be supplied through the mail, such as some medical and surgical supplies, to those that included a significant service component such as the training, follow-up, and repairs that could accompany the provision of oxygen.

To date, two of the three evaluations of this demonstration have been completed and they provide no evidence that competitive bidding has had an adverse impact on quality

or access, but it has shown that competitive bidding does lower prices. The conclusions on Polk County to date are based on beneficiary surveys and comparisons with surveyed beneficiaries in neighboring Brevard County, which was chosen as a comparison county because it has a similar population. It also contains focus group meetings with referral agents, suppliers and beneficiaries in that county, and an analysis of both rounds of bids.

The final evaluation of Polk County will include additional site visits, interviews of suppliers, and referral agents to measure access and quality during the second round of bidding that occurred in that county.

With respect to the San Antonio site, there has been a baseline beneficiary survey, focus groups with stakeholders and an analysis of the bids that were submitted. The final evaluation for San Antonio will have a follow-up survey for information from beneficiaries and suppliers to assess access and quality during the San Antonio phase.

The spending information that we have has been based on the prices that were bid. The final evaluation will have a claims analysis that will determine what impact, if any, competitive bidding had on the volume of DME that was supplied

under the demonstration.

Based upon the first and second evaluations, the market functioned largely as was hoped. There were 73 bids from 30 suppliers in Polk County and 180 bids from 80 suppliers in San Antonio. This suggested a large number of suppliers are willing to participant, though not all, in competitive bidding.

Of the 16 winners in Polk County's second round, half were winners in the last round and half were new. This suggests that the competitors weren't eliminated in the first round, but instead returned to challenge winners in the subsequent round. And this suggests that competitive bidding can be sustained over a series of rounds.

We also found that Medicare spending could be reduced by $8.5 million or about 20 percent off the fee schedule prices assuming no change in volume. Savings generally increased in the second round of bidding. The agency's administrative costs for operating this demonstration were $4.8 million, $1.2 million for startup costs. The second evaluation estimates that adding a new site with this competitive bidding system would cost between $300,000 and $500,000 per year.

Surveys and focus groups to date found largely positive results in terms of access and quality. For example,

Polk County beneficiaries reported an increase in the quality of training after one year of the demonstration, no difference in the frequency of maintenance visits before and after the demonstration, and little or no wait for deliveries of oxygen. Overall satisfaction ratings from users of DME were high before the demo and remained at high levels one year later in Polk County.

Referral agents in San Antonio and Polk noted that problems that they had with winning suppliers were often transitional in nature and could often be solved by switching to another winning supplier.

However, some beneficiaries and referral agents raised concerns about the quality of DME under competitive bidding. In Polk County, there was a decrease in the provision of portable oxygen as opposed to a stationary concentrate or other forms of oxygen. Portable oxygen may be important to the quality of life that may have health benefits conferred by the additional mobility it gives a beneficiary. Evaluators note that the decline in portable oxygen could be due to a coverage policy change that occurred during the demonstration. However, in Brevard, the comparison county, there was no decrease in the amount of portable oxygen over the same period of time.

Also, in Polk County beneficiaries and referral agents complained about the substitution of less satisfactory urologic suppliers. And in San Antonio, improper equipment for wheelchairs was sometimes delivered and the repairs were sometimes not satisfactory.

The evaluators concluded that the problems warrant monitoring and follow-up. And while characterizing all their observations as preliminary, the evaluators conclude that the results, on the whole, have been positive.

Based on the Commission's comments from the last meeting, there was an indicated interest in building upon the results to date of the DME demonstrations, so we've brought you this draft recommendation for your possible consideration. This draft recommendation would allow Congress to give the Secretary authority to implement competitive pricing for DME as demonstrated, unless a third evaluation presents significantly different evidence than the first two evaluations. Congress would have a fixed period of time to review and approve any implementation plan.

This second recommendation is intended to encourage the Secretary to pursue additional competitive pricing demonstrations by removing the need to seek legislative

approval for additional demonstrations of this sort. Thus, the Congress should give the Secretary demonstration authority to initiate competitive pricing demonstrations.

In our third draft recommendation, because it seems important to balance regulatory flexibility and congressional oversight, we have drafted recommendation number three. By this recommendation, for demonstration that prove successful, the Secretary should have the authority to implement competitive pricing. The Congress would have a fixed period of time to review and approve any implementation plan.

On this next slide, to develop an idea of the potential for new markets if competitive bidding were to be expanded beyond the two markets or eight categories of items for which it's been tested, staff has made some measurements of existing DME markets. We used a 5 percent sample of claims for DME in 2001, which captured over 50,000 DME suppliers.

Preliminary results suggest that 75 metropolitan statistical areas are at least as large as Polk County, which was the smaller of the two sites. Those MSAs include about 20 million Medicare beneficiaries.

We also made a preliminary estimate of the competitiveness of markets based on the type of DME. The

measurement of competitiveness was the Herfendahl index score for an MSA or for a state-wide rural area. The Herfendahl index reflects a concentration of the market. Thus, a market with four competitors that each had 25 percent share of the market would be more competitive than a similar market with four competitors but in which one competitor had a dominant 70 percent share and the other competitors had 10 percent share each.

Using this measurement of market concentration, the markets for oxygen and hospital beds and medical/surgical suppliers across the country are relatively unconcentrated, and by this measurement would be deemed to be relatively competitive. By contrast, the markets for DME drugs and nutrition suppliers are relatively concentrated and would be characterized as less competitive.

However, as an important caveat on that research, the demonstration of competitive building yielded lower prices for DME, drugs, and nutrition as well as oxygen, hospital beds, and medical/surgical supplies. This would suggest that perhaps the Herfendahl index is not the best indicator of the potential effectiveness of competitive bidding, especially because it fails to account for the behavior of new entrants in a

reconstituted market.

Research of this nature could be expanded. We could explore different definitions of the market or take it in other directions as you see the need for such research.

So to conclude this representation, that's just to give you sort of a taste, I'll go back to the recommendations and we'll open up the discussion.

MR. HACKBARTH: What I would suggest is that we take these in turn. Let me ask first whether there are any questions or comments about the CABG demonstration?

MR. FEEZOR: Glenn, just two comments generally, sort of more of an amplification, I think, of the findings.

First off, Anne and Sharon, good job, and I'm comfortable with the general direction of the recommendations.

In our description of the competitive bidding process, I'm not sure that we might be simplifying things a little bit too much. I think there is two thresholds of competition. First, is to be the approved vendor, which is a competitive procurement at the governmental level. And then there, in fact, is a second level competition if you are an approved vendor, to in fact for those services.

Certainly, cost is very easy to tease out at that

first level. But at that second level, competition may happen at more than just cost and quality and price. And I think just simply clarifying that or making that a little more explicit might be helpful.

The second, and Mr. Chairman, this would go to probably the second recommendation, just a concern that I have as far -- certainly expanding competitive bidding is appropriate. But I think there are categories of services beyond the two that you focused on here where, in fact, the results of competition may, in fact, begin to cut into critical core services that a community or a medical system might have, would be an area that I think you would at least have to think about that, as far as saying is that an appropriate new category in which competitive bidding might apply.

So that's just, as we go forward and as perhaps the Secretary -- assuming that the authority is granted -- begins to explore that, I think there would be a word of caution for those areas or categories of services that might be injurious to fundamental infrastructure of other health care services that might be provided in the area.

MS. MUTTI: If you had any examples of what you were thinking of?

MR. FEEZOR: I'm thinking, and I should defer to the true experts in terms of Mary and Ray in terms of rural areas, but there may be certain services that are provided by your medical centers to some rural areas that sort of are able to make sort of the economies of scale necessary to maintain either core services or other services that simply may not be as adaptable to competitive bidding as you might thing.

In the report, I think you were very clear talking about that certain rural areas may not be appropriate for that, and I guess that may cover it.

MR. HACKBARTH: I'm a little bit uncertain about this Allen, so let me just pursue it for a second. If in fact, it's a service, sort of a sole community provider, and essential to the community, it wouldn't lend itself to competitive bidding to begin with. There wouldn't be competitive alternatives. So it wouldn't be a prerequisite for it. By definition we're talking about markets where there are multiple alternatives readily available so that no one supplier is essential, almost by definition.

MR. FEEZOR: Yes, when you start by defining it by market, which of course the last slide talked about identifying areas, at least as far as these categories of services.

DR. NEWHOUSE: This isn't directly on the recommendation, so if Bob and Nick want to talk about the recommendations, I'll pass.

MR. HACKBARTH: In fact, let me just leap in here and say a word about the recommendations, specifically draft recommendation one. At the end of the first paragraph, we have the clause saying that unless the third evaluation presents significantly different evidence. Unless there's an objection from the commissioners, what I'd like to do here is drop that clause, go ahead and vote on the basic recommendation that the Congress should give the Secretary authority, hold the recommendation until the final evaluation comes available, which by statute as I understand it should happen sometime this summer.

Once we have the final evaluation in hand, the staff will review the analysis. If it is, in fact, consistent with the earlier evaluations, consistent with the analysis included in this draft chapter, then we would go ahead and proceed to issue a final recommendation, provided the Commission approves that when we vote. So specifically what I want to avoid was issuing a final recommendation before we have seen the final evaluation.

Without objection, that's how we'll proceed on this, so we'll drop the unless language and we will vote but then hold the recommendation in abeyance pending the final evaluation.

DR. NEWHOUSE: This goes to the comment about markets because there was something in the text that I found confusing about, in the comment on price, there was a statement that bids may need to be adjusted to promote comparability. And then it said the two most significant factors are input costs and relative health status.

I assumed if we're taking bids for a given geographic market, in which case there wouldn't need to be an adjustment for those factors. What I'm concerned about is an issue where say, like a lab where I bid for a market, say Dallas, but I'm actually located somewhere else, my lab is somewhere else. And I say gee, I have higher cost because I'm in a higher wage area than Dallas. It doesn't seem to me we want to adjust for that.

MR. HACKBARTH: That makes sense to me. Anne, Sharon, any reaction?

MS. MUTTI: Yes, we wrote that originally very broadly, but I see your point.

DR. WOLTER: A couple of things. I guess I'll

address the bypass surgery demonstration.

I think one interesting aspect of that's related to the upcoming conversation on incentives and quality because in essence there's a merging of Part A and Part B payments that goes on there, which I think is a good thing, at least in the sense that it fosters people having to come together and work together in care. So just to point that out.

Then a little bit to support Allen's comments. I think that we do have to recognize with projects like this that there is a universe of DRGs around which there's a pretty healthy margin. And then there's a universal around which there is not such a healthy margin. And to the extent that in a market, care is shifted to a given organization where that margin is healthier, it becomes more difficult for the organizations not chosen perhaps to continue to provide the full array of services. And I don't know how one follows that as these projects are done, but I think it should be kept in mind.

Then the other thing, I think, is the things that happen after projects like this become more common, and I'm thinking of we already know there's variation in utilization that varies substantially. In one part of the country bypass

surgery has a much higher utilization rate per thousand Medicare recipients than in other parts of the country. And angioplasty similarly.

So one could imagine responses, in terms of substitution of care, angioplasty for bypass surgery, et cetera, as projects like this are implemented. And I think those things should be kept in mind and followed.

DR. REISCHAUER: We're talking about them in order? I have an observation or a question for Anne about the CABG demonstration, which struck me as a confused demonstration in the sense that it was trying to maybe pursue two objectives which couldn't be pursued at the same time. One is sort of the question of is this a better way to structure payments? Can we do it cheaper this way without compromising access or quality?

And in that case, we come up with how the bids were lower overall and as an organization that says we're trying to set Medicare payments for the efficient provider it should be provided in the efficient way. But it that kind of experiment or demonstration, one would want to include high-quality, medium quality, and low quality and look and see if we went to a payment mechanism like this, is current quality maintained? Or not degraded?

This demonstration didn't do that because it only took the high-quality folks and then it really can't say anything about the impact on quality because they were there already, and they're there for some other reason. So I don't think we've shed any light on that.

The other objective could have been to shift demand to high-quality providers. And on that score it failed. That's really the only thing that was demonstrated, it strikes me, in this demonstration.

So if we are to encourage CMS to go ahead with demonstrations, I'd want it to go ahead on ones that we really learned answers to important questions on, rather than confusing the issue.

MS. RAPHAEL: I had the same observation on the CABG one, which is it didn't stimulate increased demand and increased volume for the providers selected. And I was kind of interested in that, because in your chapter you talk about several things, part of which had to do with CMS's reluctance to give some incentives to these selected providers, like a designation of centers of excellence or waiving of coinsurance. To me that was important. I'd like understand why there was an absence of those incentives. Some of the other variables had

to do with the difficulty of breaking referral patterns.

But could you comment on this policy toward giving incentives towards the selected bidder?

MS. MUTTI: I don't know that I can speak definitively but I can imagine -- and there's been a lot of controversy about using the title centers of excellence, and whether overall that there was a comfort level among the industry that that was the appropriate title to use. They felt that some of the very good excellent facilities didn't even apply to participate in the demonstration, and they therefore didn't like the idea that this would be named centers of excellence. They didn't think it was as inclusive as it could be.

And actually, when this demonstration was done it wasn't even in the title of the demonstration. So I don't think that CMS or HCFA, at the time, had ever even promised that they could use the centers of excellence moniker in marketing this.

It was never the agreement -- there was concern on waiving the deductibles and coinsurance because the participating sites just wanted to do it for those people who didn't have supplemental coverage. And there was a concern

that that was inequitable in how they treated that.

But I think certainly internally that's been an issue that we had talked about. If you wanted to redo this, is this an area that maybe you could get some real improvement on, if CMS wanted to take more of a leadership role and be out in front and make a more public statement about those winners. But so far that has not been their choice.

MR. HACKBARTH: So we've made a specific recommendation with regard to DME. We have not on CABG. The reasons that we've discussed here are basically the reasons for not saying something specific in support of the CABG demonstration.

MS. MUTTI: Can I just follow up on Bob's point?

Are you expressing interest in any kind of demonstration that would more broadly test the idea of doing a bundled payment for A/B but do it across all types of facilities, high quality, low quality?

DR. REISCHAUER: That's one demonstration that it would be interesting to find out the answer to. Another one would be one in which you're asking can you improve the quality of care across the board, meaning change low quality into higher quality people by changing the way we structure

payments? But that wasn't tested in this, it was a closed samples of participants.

MS. MUTTI: Actually, they have talked about going forward with this consortium of Virginia cardiac hospitals, some of which are much higher quality than others, or at least have had better results than others. And so if they do end up going forward with that we may get a little insight into that.

MR. SMITH: On Bob's point, I think it's tough to imagine, Bob, how you would organize competitive bidding among low quality providers.

DR. REISCHAUER: The question is are you trying to change quality or are you trying to save money without degrading quality? Those are the two questions.

MR. SMITH: But you are trying to do both. And it seems to me, that assuming that this works, you would only reward high-quality providers in the first round of competition. If the market works, competing suppliers' quality ought to improve so that they can play in the next round.

DR. REISCHAUER: You're in the next chapter, though.

MR. SMITH: I understand. But it shouldn't be an objective of a competitive bidding demonstration to see if it works down the quality ladder. The question should be can you

save money without having quality degraded?

And an interesting related question is does the quality among non-winning competitors improve so that they become eligible for the next round? That would be the testify of whether or not this market is producing higher quality.

DR. REISCHAUER: We didn't do that with this hospital thing. We didn't have a second round.

MR. SMITH: I agree, but we ought to maybe observe in the text that if we proceed with additional demonstrations, they ought to be structured so that they test that.

Glenn, I have one other minor comment. There's sort of an aside, which I've now lost, where you suggest that there may be other market objectives protecting access of small providers, more comprehensive providers. I think I'd get rid of that suggestion. Senator Durenberger will understand, it is so tempting to write these things -- and particularly for his former colleagues to write these things -- so that everybody is protected, set-asides and carve-outs and hold harmless provisions. Congress will take care of that without us encouraging them to. I'd get rid of that reference.

DR. REISCHAUER: That's not CMS or MedPAC's responsibility. We're not elected by the people, at least I

don't think we are.

MR. HACKBARTH: You're in deep trouble if we are.

DR. REISCHAUER: I am.

Can I ask Sharon a question? You use the term throughout the section on DME about suppliers and I'm just wondering what is a supplier here? We talk about Polk County, 92,000 beneficiaries and 120 suppliers of hospital beds. I'm thinking, not more than 10 percent of Medicare folks could be in the market for hospital beds in a single year, and that's probably even less. So that's 9,000 divided by 120. These providers are selling 92 beds a year?

Where are they located? They might not sell any. So I'm wondering, is this really any kind of measure of market? The notion of supplier. Because some of this stuff you can probably buy on the Internet.

MS. CHENG: Certainly some suppliers are mail-order. And one of the challenges that we had in trying to describe markets for DME is to account for the fact that the suppliers for DME range from really -- even more than in home health -- from one end of the spectrum to the other. There are some suppliers that are very, very small.

And in fact, when we use a 5 percent sample to look

at nation-wide claims, we picked up 50,000 suppliers. I think that I might have missed another 10,000, 20,000, even possibly 30,000, because their volume is very, very small. Also, because you don't have to have a presence in the market physically, my definition of a supplier was someone who had supplied something to someone in that market. So all you had to do was buy something from the supplier one time and that was a supplier in the market.

DR. REISCHAUER: We should just have a couple of sentences somewhere in the chapter saying that.

MR. HACKBARTH: Let me just go back to the CABG issue for a second. I just want to be clear about what I think is the message, and correct me if I'm wrong.

We're not saying that this is an idea that couldn't be made to work. What we're saying is that there are a lot of loose ends that would need to be resolved. And the thrust of what we're doing here is saying, trying to identify the highest priority opportunities. Given all the loose ends surrounding CABG, we don't see that as at the same level of development, if you will, as DME. Moving ahead with DME is much more straightforward at this point.

Hence the recommendation to go ahead with DME and

just some discussion of the CABG recommendation. Is that a fair summary? Joe?

DR. NEWHOUSE: I don't disagree with that, but I would have said I thought it important to try to proceed with more integration of A and B, more actually for quality purposes than for cost purposes. I'm a little concerned that we don't shove that kind of demonstration off into a cul-de-sac.

MR. HACKBARTH: In fact, that's why I wanted to go back to the tone, Joe. I don't want the tone to be negative, that we think that this is something that shouldn't be pursued or is fundamentally flawed. In fact, there's a lot that's interesting about it, including the merger of A and B. I'd like to be clear that the reason we're not recommending making the same type of recommendation for CABG as for DME is not because there's nothing interesting or important there. It's simply that it's not as clear cut at this point is we think DME is. So maybe it ought to be pursued --

DR. NEWHOUSE: The example that we talked about was the center of excellence problematic language. But one could still set that issue aside. That's quite separable, I think, when trying to combine A and B in some given local markets and proceed along with some kind of demonstration of that, of a

bundled payment.

MR. HACKBARTH: Again, the further exploration through demonstration, not only don't I have any objection to it, but I think it may be worth doing. With DME we're saying we need to be moving towards incorporating this in the program. We think this is so promising that the next step is towards implementation. We don't think CABG is there yet. And that's the contrast between the two in this chapter.

DR. NEWHOUSE: It's a little late in the day, but what about some kind of recommendation on encouraging demos of bundled A and B payment for certain procedures? We can point back to CABG as an example.

MR. HACKBARTH: How do people feel about that?

DR. WOLTER: I'm really supportive of this. I think the intention on the DME is very much driven by looking at costs. I think what we're talking about with CABG conceivably could be extended to other diagnostic areas as looking at ways of creating better coordination of care and ultimately get to better quality measures.

Now in some cases that may save costs. In some cases that could add cost. We wouldn't know until we tried it. So I think the emphasis is a little different. But I think this is

an opportunity, maybe, to put this on the table.

DR. REISCHAUER: I think Nick's right, but I don't think this demonstration shed any light on that question.

DR. NEWHOUSE: That's why we want some demonstration.

MS. MUTTI: I guess one thing to think about, too, is whether this fits in the quality chapter more than this chapter? Sharon says it's discussed there, too, in general.

MR. MULLER: But the CABG example is both -- I mean, I think it's well written up here. It's an example of why it takes so long to get these demonstrations going and it had more starts and stops than things like this should have. So I think whatever demonstration should learn from the CABG one, in terms of not spending eight or nine years.

I remember going through that and there's a lot of hope in the beginning of participating in it, and the enthusiasm for it dampened very quickly. And I think the chapter illustrates why.

If we look at more demonstrations, we should learn from the CABG one.

MR. HACKBARTH: We've got two paths that I see, and we need to bring this to a conclusion. We've got a tight schedule this morning.

One is to have the staff draft up an additional recommendation encouraging demos that involve combining An and B, and Joe you could help them do that.

A second is we do have a draft recommendation that currently says Congress should give the Secretary demonstration authority to initiate competitive pricing demonstrations, sort of a generic statement about competitive pricing demonstrations.

We could simply make it clear in the text beneath that that we think that this is a particularly promising, important area and we urge that further consideration be given to it. If that's fine with you, just have the text language.

MS. RAPHAEL: I just wanted to get a little bit of clarification on the role of Congress in authorizing the demonstration. And then in it both recommendations one and three there's a role for Congress in reviewing the implementation plans, and doing that in a fixed period of time.

So I just would like to know what the current jurisdiction of Congress is in this area and what exactly you have in mind in your proposal?

DR. MILLER: I think what we were thinking of here is that we felt like we needed the Secretary to have clear

authority to pursue these kinds of demonstrations, competitive bidding. So that's sort of the first half of the -- if you want a way to focus on it, is recommendation two. So a clarification that the Secretary has the authority to pursue these demonstrations.

Then, when demonstrations like this get to the implementation stage, presumably you have positive results and you're moving to implement in a given market area. But because these would often represent significant changes in the way Medicare pays and purchases services, we felt that there should be at least an opportunity for Congress to have some review of this before it goes into the field as it's implemented. That was the line of reasoning.

DR. REISCHAUER: Congress would have to give CMS authority to implement, as well as to demonstrate. And that's the big jump. But they would probably be reluctant to give that authority without some notion that when the results came back and the project was moving forward they didn't have some ability to say hey wait.

DR. MILLER: Just to say, in number three it does say the Secretary should have the authority to implement, and then there's that second thought.

MR. HACKBARTH: We're trying to create a bias in favor of action, but recognizing the Congress has legitimate, important prerogatives here and ought to have the opportunity to say no, that's just outside the delegated realm, we won't accept that.

MR. DURENBERGER: What's missing for me -- first, I think this conversation is really, really helpful to the final product. As I approach the age where it's either a wheelchair or a CABG, I don't mind competitive bidding for wheelchairs, but I don't want competitive bidding on response to my -- I ain't buying on money, I'm buying on something else. So whatever we can to be helpful would be helpful to me.

But the most help to Congress, because Congress is not Congress is not Congress, if it can be done is to give them some advice in response to using market competition in the transition from an administrative pricing system where everybody makes their own choices and what not, to a "competitive model."

And those of us who served on the competitive bidding pricing commission, whatever it was called for Medicare+Choice, learned some valuable lessons which are not necessarily reflected in the advice we're giving the Congress on using

market competition. I'm sure that the experience between 1997 and today has given us some valuable experiences about how do you identify the product? How do you identify who is supplier, provider, whatever it is? How do you deal with the realities of a marketplace that's used to operating in one kind of a system, transitioning to this thing called competition?

And I won't try to belabor the point now, but I do think people in Congress, before they jump to the conclusion that competitive bidding is a solution to a problem, need some advice about the experience that we've already had in trying to transition certain phases of this from administered pricing to a competitive, what they can expect.

Obviously some of these recommendations have a short time line, and I think that's a reaction to the fact you don't want people messing around with the Congress between the time you make the recommendation and so forth.

So I'm trying to suggest that if there are some "lessons," process-related lessons that we've already learned, from this competitive -- that we need to speak to that.

MR. HACKBARTH: Could you give an example of what you mean by a process-related lesson?

MR. DURENBERGER: First, I've already mentioned, how

do you define products so that there's a common agreement on the product? How do you define the producer or the seller or the supplier or something like that? How do you build in the right set of the communication, the politics of it? And I'm trying to avoid going into the experience that we had on competitive pricing, but we started out on what many of us believe was a right track and we ran into a lot of political impediments which some of us, Bob included, anticipated at the first meeting, I think, because we knew they existed.

Rather than spending four or five years going down a particular tracked called market competition or competitive pricing without the benefit of that experience, I am simply suggesting that if we could define that experience in some way it would be a valuable add-on to this whatever the report is that's going to come out sometime later in the year.

MR. HACKBARTH: The way I conceive of this is there is a large and very important philosophical debate about the virtues of competitive pricing versus administered pricing, and that is very important. What we're trying to do is go to a lower level of abstraction and say wherever you stand on that major philosophical question, there may be targets of opportunity within the Medicare program that do not raise such

complicated, sensitive issues. DME being an example of that, an example of low-hanging fruit where we may have less of an ideological divide, because of the nature of the product, the nature of the markets involved, the implications for quality, service, access, et cetera.

MR. DURENBERGER: If you say that I'm fine with it. I'm just arguing the context here.

MR. HACKBARTH: Do people agree with my characterization of where we're trying to be?

We do need to move ahead with our votes so we don't fall too far behind schedule. So again, as a reminder, we are deleting the clause that begins with the word unless.

All opposed to the recommendation as amended? All in favor? Abstain?

Okay. As I said earlier, we will hold that pending a review of the final evaluation.

Draft recommendation two. All opposed? All in favor? Abstain?

And draft recommendation three. All opposed? All in favor? Abstain?

Okay, thank you very much.

Next is comments on CMS's social HMO demonstration

evaluation. Tim?

MR. GREENE: Good morning. I will be discussing developments in the long-running CMS demonstration of the social health maintenance organization.

The Commission is required to make recommendations on the future of the demonstration six months after CMS submits its final report on the demonstration. The CMS report was submitted to Congress on February 28th, so your report is due August 28th. This is the last scheduled public meeting that you're holding before the due date for the report.

I'll be discussing action by CMS dealing with the social HMO. Then I'll review key findings from the CMS evaluations of the demonstration. After discussing some principles you may wish to consider, I'll present two recommendations. I will conclude with a review of issues that arise in considering the social HMO that go beyond the scope of the current recommendations and report.

Briefly, what is the social HMO? We've discussed this before so I'll be brief. As you know, the S/HMO is a managed care model that seeks to integrate acute and long-term care. There are two types, one the first generation or S/HMO I model founded in the 1980s, which emphasizes case management.

The second generation plan, established in 1996, that places an emphasis on geriatric care. All these plans are paid with an add-on payment 5.3 percent higher than county Medicare+Choice payment rates.

There are four plans in the country. They vary greatly in size. Though we talk about social HMOs as one entity, they're very different. The smallest, Kaiser in Portland, has 4,400 members and two others, SCAN in Long Beach and Health Plan in Nevada, each have almost 50,000 for a total of 113,000. The first three are the first generation plans founded in 1985 and HPN, the Nevada plan, is the sole second generation plan.

We turn now CMS actions, both originally and the more recent ones. The social HMO demonstration was started in 1985. CMS, then HCFA, followed up with an evaluation from 1985 through 1991 essentially, with results published in the early 1990s.

The BBA required the Secretary to submit two reports to Congress. The first was submitted in February, 2001. In included additional findings on the first generation plans and preliminary findings from the new evaluation by Mathematica Policy Research of the second generation plan. I'll be going

over the evaluation findings in a moment.

The 2001 report recommended that the existing plans be converted to standard M+C plans and be paid under the same risk-adjustment approach used with M+C plans that had been introduced into M+C with a transition period.

The second report, sent to Congress this February, is the final evaluation report on the project. It does not include recommendations. It was always understood to be an evaluation document and it was expected to involve recommendations.

However, in last month's annual notice of payment changes from Medicare+Choice, CMS proposed to bring S/HMOs on to risk-adjusted payment using the phase-in schedule that applies to all M+C plans. The notice proposed that the plans receive a special frailty adjustment in addition to the standard Medicare+Choice risk adjustment during the transition.

Over four years, the special S/HMO payment add-on would be gradually phased out. The frailty adjuster would be calculated at the plan level and would apply to all plan beneficiaries, and the payment adjustment would apply solely to the social HMOs had not to other M+C plans. I will now turn to the evaluation information.

The first evaluation found that the social HMO plans did not effectively integrate acute and long-term care. Coordination between case managers and physicians was particularly poorly developed. Since the final evaluation of the first generation plan, the Kaiser plan in Portland, the group model HMO had some success in integrating care. There was some evidence in the second evaluation that the second generation plans has successfully directed benefits to targeted members.

The first evaluation found mixed effects on service use with lower hospital use and higher nursing home use. And incidentally, the first evaluation was reflecting the health care system on the day of comparison with fee-for-service. The second evaluation compares the plan to M+C plans.

The final evaluation finds comparable results for the second generation plans. Measures of hospitalization show mixed and inconsistent results. For the overall plan population, though, there was noticeable effect on one very small subgroup. Too few enrollees were seen in long-term nursing facilities and it was impossible to evaluate an impact there, with is unfortunate because reduced nursing home use was one of the goals of the evaluation.

The plan has had mixed impacts on hospital use after the end of the CMS evaluation. Studies submitted by the S/HMOs to MedPAC found that in 1998 through 2000 discharges increased among beneficiaries enrolled in a network practice affiliated with the S/HMO, but decreased along members seen in S/HMO clinics. This suggests that a large part of the impact reflects the effect of a more tightly organized delivery system. And the findings are consistent with what was reported in the CMS evaluation.

The CMS evaluation also, the second evaluation provides a little information on the first generation plans. They went back and looked at CAHPS data on satisfaction and found that despite the fact that S/HMO plan members receive extra benefits, they were no more satisfied with their plan than were members of M+C plans.

As you may notice, many of these are service use input measures. The evaluation of the second generation plan was able to look at a number of outcome measures. That's what I'll focus on now.

The evaluation uses survey data on beneficiaries and other data and finds that there's no consistent impact on health status, self-reported health status among plan members,

with no consistent impact on physical, cognitive, emotional health and with the S/HMO performing better on some evaluation and the comparison M+C plan better on others.

In the overall sample there was no consistent impact on functional status. In 10 of 12 comparisons of activities of daily living, ADLs, there was no statistically significant difference between plan and comparison group than in 11 comparisons of IADLs. There was no consistent difference. There really does not appear to be a difference in impact on that important outcome measure in this frail population.

In general, the performance of the plan in delivering preventive services was good, better than fee-for-service, but comparable to an M+C plan, which suggests that the experience reflects often measured result with managed care plans doing better in prevention than fee-for-service but without distinct strengths or weaknesses among managed care plans.

The evaluation looked at treatment of specific chronic conditions and found mixed results, the S/HMO doing better in some, M+C plans better in others or no worse than others. The evaluators looked at potentially avoidable hospitalizations, which were taken to be indicators of -- the presence of an avoidable hospitalization was taken to be an

indication of poor ambulatory care -- and found small mixed effects.

So on all of these outcome measures, we find modest --

DR. MILLER: Tim, I want to ask one thing. A lot of what went on here, for example in functional status, there would be something like 14 or 15 measures. There might be two in which the S/HMO populations did better on, one in which M+C populations did better on, and then the remainder, the 10 or 11 in which there was no statistical difference.

MR. GREENE: Right.

DR. MILLER: That was sort of the way things played inside the evaluation.

MR. GREENE: Absolutely.

MS. DePARLE: When you say no statistical difference, do you mean between M+C and S/HMO, not between that and fee-for-service.

MR. GREENE: No, the second generation is an M+C comparison, which is more appropriate in the current context.

MS. RAPHAEL: Tim, you said S/HMO I was compared to fee-for-service, but under satisfaction you say there's no difference versus M+C. Could you explain that?

MR. GREENE: That was the only new evaluation result from the just completed evaluation, that was applying to the S/HMO I. So the recent evaluation compares to M+C and that one finding on S/HMO I is from the recent evaluation.

DR. NELSON: Can I ask a quick question also related to the evaluation?

Tim, it was unclear to me whether, on page 11 and 12, where we have the bullets, that are prefaced by an analytic statement, whether or not that analytic statement was part of the bulleted paragraph or MPR's words, or CMS's interpretation, or our interpretation.

For example, on page 12, the third bullet says the S/HMO did not consistently have lower rates of hospitalization for potentially avoidable, and so forth. And then becomes more precise and says that in 12 comparison with fee-for-service, S/HMO showed significantly lower rates in seven, higher in two, and no differences in three.

So the statement that sort of summarizes that, in a sense, represents a subjective analysis. And I want to know whether that analysis was ours or MPR's. It seems to me that if it's MPR's then we ought to state that. If it's our interpretation of those data, then that ought to be clear, too.

MR. GREENE: It's both. In some cases I'm restating MPR but the findings that they're summarizing are in front of me. I'm looking at it and looking at those comparisons and seeing -- what I'm here more likely calling small and mixed impacts, inconsistent, different signs, different magnitude in different samples.

DR. NELSON: Somebody is going to take objection with our characterization of the data on some of this, think. I'm willing to do that but I think we need to be able to defend it. It seems to me that if we're citing someone else's study, we ought to -- to the degree possible -- also cite their analytic conclusions on the data.

MR. GREENE: To distinguish, I think I'm reflecting their analytic conclusions, but if you want the association tighter, I can make that. But this is also my conclusion, as well.

DR. REISCHAUER: I don't, quite frankly, understand your point, Alan. The first sentence says does not have consistently lower. And to me, to have consistently lower, in all 12 cases it would have to be lower. And then just explain why it's not consistently lower, what the distribution looks

like. That's a statement of fact, it's not a judgment by an analyst.

DR. NELSON: I guess it's a different way that your discipline would interpret that paragraph, as compared to mine.

DR. REISCHAUER: I forgot, you're part of an art, not a science.

[Laughter.]

DR. NELSON: I suspected if everybody agrees that that is true, but it sounds like seven out of 12 represents some level of evidence.

DR. REISCHAUER: Good enough for medicine?

DR. NELSON: Yes. If you need all 12 in order to make that kind of a statement, I guess that's true.

DR. NEWHOUSE: Actually, I think we're even giving the benefit of the doubt here because technically you should make a correction for multiple comparisons. Probably if you did that, two out of 12 would not be significant. So the idea being that if you look 12 times at random, you'll be more likely to find something significant at the 5 percent level than if you only look once.

MR. HACKBARTH: I have no problem with our staff drawing inferences from data. We do that regularly. It

there's ambiguity about whether it's our conclusion or Mathematica's, I think that ought to be avoided. I think it ought to be consistent and clear, are we talking about our characterization or theirs.

In any case, if I'm looking at the right place, in each case we actually cite the data afterwards. It's not like we're just making a subjective statement without then reporting the results. So let's just be consistent and clear about whose characterization this is. I personally can live with it either way. To me the important thing is the numbers that come afterwards anyhow.

Tim, do you want to pick up again with the presentation?

MR. GREENE: We turn now to several principles that you may wish to consider in preparing your recommendations. Medicare is a national program with a uniform benefit package for all beneficiaries. Extra benefits provided by the social HMOs are only available to a small number of beneficiaries in about a dozen counties in the country.

Second, certain plans should not be advantaged relative to other plans. The 5.3 percent add-on received by the social HMOs unfairly advantages them relative to others.

We think this raises questions of equity across beneficiaries and across plans.

Second, we need to always remember the these plans are demonstrations. The federal government initiates demonstrations to identify promising techniques that then can be diffused elsewhere. The plans should be evaluated, at least in part, based on the effectiveness of the care they render.

Third, the Commission has previously recommended that the long-term capitation payments for frail beneficiaries should be based on their characteristics not on the type of plan in which they are enrolled. Or as we put it here, payment follows the person rather than being linked to the plan.

Our first recommendation addresses the S/HMOs and Medicare+Choice. It proposes that demonstration plans be converted to M+C plans. Under this recommendation, at the conclusion of the demonstration, on December 31st of this year, the end of this year, the Secretary would request that the existing four demonstration plans apply to participate in Medicare+Choice. They would become coordinated care plans in the M+C program.

When the existing plans become M+C plans after the end of the demo, they would not be required to continue to

offer the expanded benefit package that they offer as demonstration plans. However, there would also no longer be a payment add-on, a 5.3 percent add-on, which was intended to compensate for the extra benefits.

The plans, as M+C plans, could of course continue to offer whatever benefits they wished, and could deal with the additional expense, if any, with savings elsewhere or with premiums charged to members.

During the transition, after the end of the demonstration, plans would be paid based entirely on CMS risk adjustment, M+C risk adjustment, with a frailty adjustment added on. As we understand the frailty adjustment, given existing data, it would have to be calculated at the plan level and it would then be applied to each beneficiary.

Under this, we're simply dealing with the period through 2007 when we foresee a frailty adjustment here as applying just to these former demonstration plans, not to M+C generally.

DR. MILLER: so just to summarize really quickly, the idea is they become like regular Medicare M+C plans, but for the period 2004 to 2007 they're paid 100 percent on a risk-adjusted basis plus the frailty adjuster. The notion being

that that will track the kinds of populations that these plants are supposed to have. We note that the frailty adjuster is at the plan level and we're about to come to a recommendation that says in a perfect world, post-2007, that should be beneficiary-specific. But we recognize in the interim we get there.

DR. NEWHOUSE: Can you tell me what that means, plan level? Isn't that just an average of beneficiaries in the plan?

MR. GREENE: Not quite because this issue arises in the context of using survey data, functional status information that's not available for all plan members. It's currently collected by CMS in the Health Outcomes Survey for samples of members of all demonstration and M+C plans. The intent, CMS's intent currently is to use that data to calculate a plan average estimate of a frailty measure and then apply that on average to all plan members. It's not the perfect way of doing it but --

DR. NEWHOUSE: What's the pacing? I'm sorry to hog the floor here, but is this budget neutral or what? How is the frailty adjuster calibrated in terms of how much more money we pay for three ADLs versus two ADLs?

MR. GREENE: I don't know. I don't think its budget

neutral. It wouldn't be budget neutral but the overall program is being implemented in budget neutral fashion, so I suppose is the feedback there. As far as I know.

DR. NEWHOUSE: How is the frailty adjuster set then? What's the conversion factor for the frailty adjuster?

MR. GREENE: We know it's been the frailty adjustment modeled and that CMS is ready to implement. We haven't seen the model.

DR. NEWHOUSE: I speak for myself, I'm a little bit reluctant to vote for this until I know more about what this is all about.

MR. HACKBARTH: Comments on that particular issue?

MR. SMITH: Tim, why doesn't the risk adjustment pick up frailty? What is it that means when need an additional frailty adjuster if we're using the M+C risk adjuster?

It sounds to me like an elaborate disguise for a transition payment, which may be entirely appropriate, sort of a phase out of the 5.3. But I don't understand, unless we think that the current risk adjustment apparatus misses frailty, in which case a frailty adjuster makes sense, which we know later.

MR. GREENE: It is basically an empirical finding.

There's been a large body of work in the last five years by CMS and independent researchers that finds that for beneficiaries with multiple ADL limitations and other indications of frailty, the existing risk adjustment model underpays slightly, somewhat.

DR. MILLER: But we're going to come to our second recommendation which is going to address the frailty adjuster. And one of the fundamental questions is to evaluate both the need for it and then the mechanism to tie it to the patient level. There is some indication that the risk adjustment, as it stands, falls short on this count. But on the second recommendation, we're trying to push that very question, which we're going to come to.

MR. SMITH: Mary and I were just talking about, if we know enough to apply the frailty adjuster in addition to the risk adjuster to the S/HMO population, why don't we know enough to apply it to the rest of the M+C population?

MR. GREENE: We'll get there.

MR. SMITH: If we do know enough to do that, why don't we recommend it?

MR. GREENE: The difficulty, which I'll touch on in future issues, pertaining to Medicare+Choice county rates, the

rate book. When applying a risk adjustment or changing a risk adjustment method you need to adjust county rates to be consistent with the risk adjuster you're applying. We don't have the frailty data for counties that would allow that adjustment. It's a technical problem. It's a broad risk adjustment problem. But it does impinge on this particular case.

MR. HACKBARTH: So this wouldn't preclude it being ultimately adopted for the whole M+C population, but what you're saying is that the data necessary to do that do not exist at the point?

MR. GREENE: Yes.

MR. HACKBARTH: So it would be limited to this particular group.

DR. STOWERS: I'm just wondering, is the inference here that the frailty adjustment would bring about a certain set of benefits? Kind of looking at this from an access issue. The S/HMOs kind of had a certain set of objectives and benefits. Are we thinking that this is a way of spreading a particular set of benefits? So if an HMO later on or Medicare+Choice plan is going to be receiving these frailty adjustment or whatever we're going to call it, does that bring

about a certain set of -- so we're getting rid of a certain set of benefits that goes along --

MR. HACKBARTH: The mandated benefits would be dropped. They would no longer be required to provide the additional S/HMO benefits, if you will. The idea, though, is that if they are, in fact, enrolling a frailer population, that they would get additional payments which would give them resources to use as they see fit to best care for this population.

DR. REISCHAUER: I have the question, Tim. When these things disappear or are transformed, do the individuals who are in them have the rights to Medigap purchase the same way as a plan disappearing from your area did? Because I would be reluctant not to have some kind of transition for existing participants if these folks have to go into the unadjusted Medigap market.

DR. HARRISON: We're pretty sure that they do have those same protections. We need to consult the law, but we're pretty sure they do.

DR. MILLER: First of all, on the frailty discussion, we have a second recommendation that addresses some of these issues.

And then in your presentation, don't you have some additional information on what their other options are?

MR. GREENE: I can go to that now.

MR. HACKBARTH: Why don't you go ahead to draft recommendation two, since it is on point, for the recent conversation.

MR. GREENE: Now turning to the recommendation that goes to risk adjustment for frail populations beyond the S/HMOs and after the period of the end of the transition after 2007. Under this recommendation the Secretary would continue working to improve risk adjustment for all M+C and specialized plans. But the goal would be to improve payment accuracy overall, not specifically to direct resources to any specific subset of beneficiaries.

CMS would continue research on payment adjustment for frail populations. After 2007, when risk adjustment is fully phased in for M+C, frailty adjusters would apply to all plans, not just demonstration plans or social HMOs.

Patient payments for frail beneficiaries would be based on their characteristics, not on the type of plan to which they belong. The frailty adjuster could either be part of the established risk adjustment system, it could be a tweak

on the existing HCC model, or some other adjustment. Or it could be a free-standing frailty adjustment. This is not committing ourselves one way or another. It's simply saying improved payment accuracy and consider this particular population.

MR. HACKBARTH: Now why don't you go ahead also, Tim, and describe the options available for the beneficiaries?

MR. GREENE: We realize there's concern about the impact on beneficiaries of a change in the status of these demonstration plans. We Looked at options available for the beneficiaries in the four market areas in which they operate.

We found, looking at the current M+C data, that there are multiple plan options, other M+C plans, that beneficiaries could move to in all the four areas. These are metropolitan areas including New York, of course. In all cases, there's at least one plan that offers a drug benefit. And in three out of the four there is still a zero premium plan.

So beneficiaries could choose to stay with the former demonstration plans, which would be free to offer the expanded benefits they do now, or if they chose to move within the program, within managed care, they have reasonable options.

Turning now to Bob's point, we also considered the

fee-for-service options. And this is what you were getting at, I think. There are established protections for beneficiaries who leave plans that withdraw from M+C. It's a legal question we haven't settled, whether these currently apply to those beneficiaries, but such beneficiaries are guaranteed access to selected Medigap plans. And in some cases, are protected -- in the case of New York, which is relevant here, by elaborate state protections that go beyond federal protections.

And we need to remember that this population, as all, also have in many cases employer-sponsored insurance options, Medicaid in a small way, and VA. We're not throwing these people out on the street when a plan is suddenly forced to close. That's not the scenario we see in any way.

As I say, these plans may simply convert -- first, they're not closing. And second, they may not even change their benefit package. It's up to them.

MR. SMITH: We don't know the answer on Medigap?

MR. GREENE: No, certain.

MR. SMITH: Shouldn't we incorporate that, that the Secretary shouldn't proceed until --

DR. NEWHOUSE: Staff and the audience thinks we're certain.

MR. SMITH: Staff and the audience thinks we're certain.

DR. BERNSTEIN: [off microphone] ...that use the term demonstrations and I think S/HMOs are specifically singled out, as if they had. And they have the same re-entry into the Medigap market as other people who have lost their plans.

MR. GREENE: I've seen references to demonstrations in the descriptive material. I haven't looked at the actual legal documents.

DR. NEWHOUSE: Glenn, I don't know how many people were on the Commission at that time, but in the past we had Lenny Gruenberg come -- and this is really responding to David and Mary's question.

And he, in my recollection, made a compelling case that the HCCs, or the frailty adjustment specifically adjusting for ADLs, would add importantly to explain variation in the HCCs. So there was -- definitely HCCs were missing something that ADLs were picking up.

Having said that, the then-commission backed away from doing anything with frailty adjustment. And the reasons, seem to me, to potentially apply here as well. The first was the point already raised, what was the conversion factor.

There was no obviously ADL data element in the claims data. So there was no way to very readily set what you were going to pay for an ADL except through the survey data that were linked to the claims data, which is what's coming here.

Then there were questions about how many people were you going to have in any given plan? What was the reliability of the survey data? Maybe you can oversample here. But there were a couple of more things that were troubling, I thought.

One was that what was the reliability of the ADL determination, whether there were really two ADLs or three ADLs, for example, was somewhat in the eye of the beholder. And what accentuated that was that the difference in payment in the survey research sample was quite substantial as you incremented the number of ADLs.

In other words, there were some real cliffs in payment on ADLs which raised the issue at a minimum on the potential ADL creep.

Now having said all of that, it still remains that in the survey data, again where you're not paying on ADLs, so you're presumably getting an unbiased read of ADLs, the ADLs explain something that the HCCs don't.

But it seems to me there is a real dilemma here. As

I hear this, I don't think we've given a sufficient weight to the potential downsides of frailty adjustment.

MR. HACKBARTH: The dilemma, I think, is that currently we have a payment system that pays extra dollars based on the categorization of the organization. If it wears the social HMO label, it qualifies for an additional 5.3 percent. The data, as I understand it, is that, in fact, the organizations are quite disparate. Some are enrolling frail --

DR. NEWHOUSE: All four of them.

MR. HACKBARTH: All four of them. And sometimes even within a single organization, like Health Plan Nevada, as I understood it, there's quite a significant difference in performance between the clinic-based piece of the organization versus the network based. There are differences across the demonstration sites in terms of the population that they enroll. As I understand it, the Kaiser site is clearly enrolling a frailer population. That's not necessarily true of other sites.

So the current approach is we pay 5.3 present more based on a label attached to the organization, regardless of the fact that they are quite different organizations and they enroll different patients. Focusing on the frailty adjuster

option is an effort to say well, let's forget the label attached to these disparate organizations and have dollars follow patients. But as you point out, and I'm sure you're right, it's not as simple as it seems on the surface.

So that's the dilemma that we face, where do you want to make your mistakes? Dollars following patients with imperfect measures or paying for broad categories of organizations even though they're very different in their characteristics and performance?

DR. MILLER: I just want to say, this is talking about the period from 2004 to 2007. The second recommendation raises the question of should there be a frailty adjuster, and what should be the basis? And there's other methodologies that are not ADL-based. We had some conversations with a bunch of different parties involved in this. And there's actually one group working on a statistical adjustment to the risk adjustment model -- and I can't describe it here -- but it deals with details of the distribution, and it captures some of this, and would drive directly off of the risk adjustment model and would not work off of an ADL-type of model.

We're saying all of this needs to be looked at.

DR. NEWHOUSE: That seems unexceptionable, but the

real issue is what happens in 2004, or what do we say about what we think should happen in 2004? And whether this is ready to be trotted out for S/HMO reimbursement or not.

DR. HARRISON: Can I say a little bit about the frailty adjuster? What CMS did was they took the MCBS and looked at ADL measures off the MCBS. So that's how they calibrated the model. They said that the other coefficients had to be the same as the general population, and they figured out what add-ons would be appropriate for frailty.

Now of course, they don't really think this is an awesome model, but for the interim they think that this could do the trick.

Now PACE programs will be paid based on this, as well. I'm not sure what happens to them past 2007.

MR. GREENE: It's phased in.

DR. HARRISON: That was the notice that came out, the 45-day notice.

They've got special problems because they had very small sample sizes, as well. That's the way the model was created. It's not budget neutral. It's definitely an add-on for frailty.

MS. DePARLE: My point isn't specifically on risk

adjustment, it's a broader point.

I guess, after reading the draft chapter and thinking about this and hearing our discussion today, I'm seeking some comfort here. I feel this is sort of a depressing discussion because a lot of effort was put into this by the various demonstration sites, the clinicians and others who were involved, the Congress, Senator Durenberger and others, the Agency, many agencies, Mathematica and others. And some of us at least believe in coordinated care models and think that's the hope for the future.

I was having a sidebar with Nick saying well, should we feel good that maybe we're already doing the best we can do? Or am I wrong that this is very depressing because it doesn't seem to show, even with prescription drugs and all the good things that you think people need, that we're making a lot of progress in care.

So help me out here.

DR. HARRISON: One thing that we learned was that Kaiser learned things from the demonstration and then actually applied them to their general population. So I think, in some cases, things have been learned and techniques have been learned and they may be used in general practice.

MR. HACKBARTH: Nancy-Ann, it's not unlike M+C as a whole. There are, frankly, good organizations and there are not so good organizations. There are organizations that do innovative things, that offer an outstanding level of quality, and there are those that I certainly wouldn't want any family member of mine enrolled in. I don't mean to imply in any way that these social HMO's are bad organizations but they have different results, different populations.

To me, the fundamental problem here is paying more for a label, as opposed to paying more for performance. I don't think, based on what we've seen thus far, there's anything special about this label that merits additional payment compared to other M+C organizations, some of which may be doing these things or other very good things.

I think paying for the label is inherently inequitable when you've got disparate organizations.

MS. DePARLE: I wholeheartedly agree, but I guess what I find concerning is I don't see, from the evaluations of this so far, and everything I've read, including the materials from the consortium and others, that it has made an appreciable difference, at least not of the magnitude that I would have hoped. That this kind of service delivery model that includes

more care coordination and other kinds of services that we aren't offering, doesn't seem to produce a large effect on people's need for institutional care and other things that we don't want to have to have them undergo and have Medicare pay for.

So that's what I find disheartening, and maybe we just don't have the model right. It's been going on almost 20 years. I'm' sure none of the original beneficiaries are even still around.

MR. DURENBERGER: Thank you very much.

I particularly appreciate the comments that I've heard so far this morning because, as always, I've learned from all of them. It's no secret, and I think I've mentioned it here before, that I have been sort of wedded to this program for 20-some years of it's existence. I certainly have a concern for the model, if you will, not necessarily for the plan but for the model.

I wasn't sure exactly how best to deal with this subject and, frankly, I visited with Bob Kane because I know Bob, and so forth.

And then across my desk, as across everybody else's desk, came this fax from Bob Newcomer. So I called up Sheila

because I knew she wasn't going to be here today and she teaches twice a year apparently and this just happens to be her trip to Harvard. And because we were both involved in the beginning of this program, I asked her, in effect, what position she would be taking were she here today.

And her position, and my position, is sort of reflected, I think, best in this question which is, what should we -- not that we're wedded to four plans that serve only 112,000 Americans out of however many may be available. But really what is it that we should learn from the S/HMO II demonstration before we move the opportunity, as Nancy has said better than I could, to provide coordinated care for people who are frail, frail elderly, and so forth, before we move them into the workplace, whether it's M+C or some of these other alternatives?

It seems to me that Newcomer makes the argument, particularly I think it's at the top of the second or third page, that even though there were more than 20,000 treatment cases available, such a stratified analysis was not reported by MPR. I consider this to be a fundamental flaw in MPR's analysis and gross unfairness in the evaluation of the S/HMO model.

Then what he talks about, as you all know, is what do you have to do to change the culture of the organization in order to get the benefit of the coordinated care for all of the members?

It seems to me, that's the lesson that needs to be taken away from S/HMO II, and what these three evaluators seem to be saying to us, through Newcomer, is give us a little bit more time and eliminate the unfairness, allegedly, of the MPR evaluation. And perhaps we can help you understand what it is about this particular S/HMO II model that is adaptable, if you will, to other cultures of service delivery in other parts of the country.

That is one part of it from -- it answers your first question, which is how do we know the difference? And I think, in part, we do need to know that difference and whether it's the frailty adjuster issue which Joe's already talking about, or it's this that's important.

I agree with you that paying just for a label rather than for performance is inappropriate. But I think the issue here is not whether one plan gets 5 percent more than another plan for allegedly doing the same thing, and we don't even know whether they do, but whether or not the 112,000 people who are

currently enrolled in one or the other of these plans are getting better care?

We can debate the data as to whether or not the program is saving money by less hospitalization or something like that, but I don't know -- and I haven't heard in the 20 years that this program has been around -- that all the people that are in it are unhappy because they're less healthy or they're not getting something that they bargained for, or things like that.

So the other question that occurs to me is why are we spending so much time, so much effort at CMS? I know at OMB for 20 years -- it started with John Cogan and it's been there forever -- and in this commission, why are we spending so much time and effort over 5.3 percent on 112,000 people, unless it's going to lead us to a different approach for everyone in this country?

And I don't mean just M+C because I don't come from a part of the country where we've got any M+C. So it might be PACE or On Lok, or it might be something else in our part of the country. So my view is I'm not going to vote today to end or recommend that we end the S/HMO as of today unless some of the kinds of questions that have been raised here and by

Newcomer's paper can be better answered. We can answer them three months from now or six months from now or a year from now. I just think we ought to do it.

MR. HACKBARTH: Does the S/HMO II have a frail population, a frailer-than-average population?

MR. GREENE: It appears not, based on the data, based on even the information we've gotten from the S/HMO consortium and from CMS. It's a large plan. It moved essentially all of its M+C plan into a new S/HMO, so it got a fairly representative body of people.

MR. HACKBARTH: So we're testing techniques of how to better manage a frail population in an organization that doesn't have one.

MR. GREENE: It has a typical proportion.

One point on what we'd be doing here, we're not closing plans, we're not telling them to close down. In fact, the way the recommendation is structured, they would be given the opportunity to offer what benefits they chose and would be getting a frailty adjustment during a transition that would compensate essentially for the 5 percent add-on. As currently estimated by CMS, the frailty adjustment would give these plans more than the 5 percent they'd be losing.

In other words, they would on average end up better off comparable M+C plans. So we would not order them to close. It would, at least as structured here, give them resources.

MR. HACKBARTH: Is there an existing S/HMO that does have a frail population?

MR. GREENE: Kaiser. Kaiser, clearly.

MR. HACKBARTH: So if we want to learn about how to best manage a frail population, given this universe of four sites, we have one that's been in existence how many years at Kaiser?

MR. GREENE: Since 1985.

MR. HACKBARTH: They've been working at this for 15 years, and actually have done a lot of very good work.

So I guess I'm troubled by the argument well, we've got to allow Health Plan Nevada, which doesn't have a frailer-than-average population, go on as a way to learn how to care for a frail population when we have one site, Kaiser, that's been doing it for 15 years and actually does have a frail population.

MR. GREENE: One lesson from the evaluation, the first evaluation, and Newcomer's findings, are that a group model HMO in Kaiser or the clinic's organized system of care at

Nevada seems to work reasonably well. That is a consistent observation there. So we have learned something from this demonstration, as far as the frail go.

DR. REISCHAUER: This becomes more and more illuminating as little bits and pieces are fed to us here. I changed my mind on this from where I was when I read this the other night.

I want to say that I share very much Nancy-Ann's disappointment that what I would like to have thought would have had a very significant impact doesn't seem to have. And say to Dave that I don't find your case convincing simply because these are groups that came forward and volunteered, that thought about this a whole lot, brought in outside expertise, were well-meaning, and in the case of S/HMO II had the experience of S/HMO I to build on. And yet we don't seem to have a lot of positive results.

One has to ask yourself why continue to pay 5.3 percent. Now we're told oh, it's not going to be 5.3 percent, it's going to be a higher number. But we're going to change the label on it so we all feel comfortable, we'll call it a frailty adjustment. And then we'll take away the requirements that you provide any additional benefit.

It strikes me, I could almost go along with Dave simply because if we're going to give them the extra money, make them do the extra benefits. In a way, we're creating an even stranger situation.

Now it strikes me maybe for transition to preserve institutions, you might want to give the 5.3 declining over time for the individuals who were in the plan as of termination date. But even that's a little rocky as an argument, given what we've learned.

So I'm really left with a very uneasy feeling about the recommendations.

MR. HACKBARTH: Just a clarification. The frailty adjustment only means more dollars if, in fact, you have a frailer-than-average population, which is not true at all these sites.

DR. REISCHAUER: What you're really saying is that only Kaiser would get this adjustment.

DR. NEWHOUSE: They only have a tiny number of people. How can there be more total dollars? We've said there's more total dollars.

DR. MILLER: Relative to the 5 percent.

DR. HARRISON: Under the frailty adjuster. Now,

there's another set of things going on here. CMS, in its 45-day notice, said they were keeping risk adjustment, as a whole, budget neutral at least through 2004.

DR. NEWHOUSE: With or without this frailty?

DR. HARRISON: Not even thinking about the frailty, for all plans.

DR. NEWHOUSE: Frailty comes on top.

DR. HARRISON: Right. So if you do CMS's version of budget neutrality and you give a frailty adjuster, three of the four plans do better than other M+C plans, and one plan does worse than other M+C plans.

DR. MILLER: On net, the total dollars are less than 5 percent.

DR. HARRISON: At 100 percent, if everything was CMS's version of budget neutrality, it would be more than the 5.3. If it were fully implemented 100 percent. The simulations get tough and we can't promise that they won't move, but that's the way it looks right now.

MR. SMITH: I may be the only one who's totally confused now.

If you use the makeshift frailty adjuster, you're suggesting that the plans would get more total dollars than

they do now, or they would get more than 5.3 percent additional dollars for each frail patient? Is Bob's description right? If you apply this at the plan -- the question is are total dollars going up during this transition period? Or is just some per capita --

DR. HARRISON: It's hard to know, but if CMS's version of budget neutrality were to hold during this, I believe they would get more than they current get.

MR. HACKBARTH: But that would be not because of the frailty adjustment --

DR. HARRISON: Because of the budget neutrality.

MR. HACKBARTH: -- necessary but because of how CMS is choosing to implement risk adjustment, which is quite independent of S/HMOs.

DR. HARRISON: If you compare them to other M+C plans.

DR. REISCHAUER: But that is going to happen anyway.

MR. HACKBARTH: If you think of it in terms of a baseline, you need to adjust the baseline for what would happened.

MR. SMITH: But that's going to happen.

MR. HACKBARTH: So the current law line, if you will,

is revised upward because of what's happening with CMS's approach to risk adjustment for all of M+C.

MR. SMITH: The question that I think I am, and maybe others are wrestling with is, having done that, the baseline is the baseline. Would the additional payment beyond the M+C baseline be greater than 5.3 percent? If the answer is yes, then I end up with Bob, this is crazy.

MR. HACKBARTH: Do you understand the question? If you just look at the frailty piece alone, is that greater than or less than the 5.3?

DR. MILLER: I'm going to try and answer this. This is very confusing and the reason that you have another issue that's playing into this that doesn't have anything to do with S/HMOs, which is that CMS's methods of implementing risk adjustment for all of the M+C plans has been decided to be "budget neutral," which is the dollars going to all M+C plans would not go down with the implementation of risk adjustment, although lots of indications are that given the mix of the patients, they should.

So when we say implement risk adjustment with a frailty adjuster, these plans will continue to do well in part because of that decision for all M+C plans.

MR. SMITH: But Mark, is that going to happen anyway?

DR. MILLER: That's correct.

MR. SMITH: So it's 5.3 percent of something.

DR. REISCHAUER: Assume Dave wins the vote and those go on, assume they're going to get a payment, that assumes that you abolish them, is the payment going to be higher?

DR. MILLER: That, I think, is the part -- and Scott, you can feel free to bail me out at any point, either way.

That's the part of the analysis that we aren't particularly able to disaggregate. However, here are the things we can tell you. Scott, feel free to correct any of this.

The frailty adjuster has very different effects on plans. Some plans, like Kaiser, will do well under the frailty adjuster because of their populations, for example, in Nevada. Because of this we know that this is some of the basis of the information that we know, that they don't have a frail population. So there will be a lot of variability in the plans.

To the extent that -- and I almost don't want to bring this up because it will just confuse things, but CMS had a transition, which was Bob's point, took the 5.3 down and took

this risk adjustment plus frailty up. And this is what I want to be careful about. At 2004, when you're doing 30 percent of the risk adjustment at that point, the dollars would have been lower than the 5 percent that they would have gotten under the current arrangement. Is that correct, Scott?

DR. HARRISON: That's right.

DR. MILLER: I think that was what we were able to tease out of this. And because we said -- our proposal was to say look, they shouldn't get the 5 percent. Give them risk adjustment and the frailty adjuster on the assumption that they are supposed to be dealing with these populations. And we said do it all at once in 2004. It actually pushes the dollars above the 5 percent, I think is what we're concluding here.

Now what we could do here is to go, I think again Bob put this on the table, the notion to something where there's more of a transition.

MR. HACKBARTH: Within that. It's more dollars in the aggregate, but the dollars are redistributed. There are some organizations that would get substantially more, I think including Kaiser because of its population, and there are others that would get less than they're currently getting, again because of the population they're enrolling.

So even if in the aggregate it's more money, the dollars are redistributed based on the frailty and risk of the population.

Quickly, we're running out of time here, folks.

MR. FEEZOR: I will make mine very brief.

I guess, along with Bob and Nancy, I'm disappointed at the results. And given what we're going to be discussing a little bit later on, quality and performance and most of the dollars we're spending, I don't know that we're going to be able to afford a 20-year experience or R&D on other questions that we're going to be calling later on. So I guess I just would put this in perspective.

When I get confused by details, I try to go back to the general principles. And I Tim, going back to your slide about three slides back when you laid out principles, my recommendation would be that we reverse those three. That in fact, ultimately, as a long-term goal the payment should follow the person, which should in fact hold them accountable for the effectiveness, and then the equity, just as a thought.

MS. RAPHAEL: But I just want to be sure that somehow in this recommendation we capture a couple of things. First of all, I, like and Nancy and now Allen, just want to see what we

can learn from this experiment because we all know that one of the main issues we have are trying to coordinate care for people with multiple chronic conditions. And we have to tackle that. And there's care management, disease management, S/HMOs and a number of other forays into trying to do that, most of which up until now have not had astonishingly spectacular results.

But I really believe we need to keep experimenting in this area. And I want to capture in whatever we do, whatever is we have learned from all of this. I was out at Kaiser and this has affected what they are doing organization-wide. So I think we need to take something positive from all of this.

So I just want to be sure that this doesn't in anyway dampen the need to keep experimenting in the future. In addition to which, I do agree with what Gruenberg's points are here, which is we need to work on this frailty adjusted. There is something else out there. We need to try to define it and capture it in some valid way. And I'd like to make sure that, as part of our futuristic recommendations, we capture those points.

MR. HACKBARTH: We're well over time.

DR. WOLTER: This may be naive, but it seems to me

that in a world, if we had some appropriate measures of demographics and risks and some appropriate measures of the results we want to obtain, that the 5 percent would be paid if those results were obtained. Why wouldn't, going forward, we design this so that the money is paid when some measures of cost savings and quality are achieved?

I think that a fundamental flaw in this particular project.

MR. HACKBARTH: Since there does seem to be some real interest in this we'll do a little bit more. Go ahead, Ralph and then Joe.

MR. MULLER: While I share the general principle that the payment should follow the beneficiary, I think this 20 years of experimentation and the dying of all the dreams on that side of the table indicates that organizations make a difference. And it may not always just be a payment for a beneficiary that makes a difference.

Like the rest of you, I commend Kaiser for many of the innovative things that they do. But the thought that Nick just shared of how one thinks about paying for results versus just for inputs but also thinking about that, certain institutions have worked at this in a very substantial way for

a long period of time, and they make a difference, I think counteracts some of the sense that they just should go with the beneficiary, because obviously there's some magic ingredient that some organizations put in that allows the performance to be better.

So I think that is one thing we have to take into account as we go into case management and other such things that are the hopes of the future, that there is a difference in how institutions deliver care. So it perhaps can't just always be as neutral, just saying it should follow the beneficiary. We have to think about the settings in which people achieve success.

DR. NEWHOUSE: I'd actually like to see a different kind of recommendation following this discussion. Kaiser has 4,400 some-odd people in this demo. I mean, 5 percent can't be that decisive. I would either like to just get rid of the 5.3 percent on the grounds that Glenn said, or transition it if we must.

And then I think the second question is what do we do then about the frailty adjuster? I don't think there's been enough brought forward to convince me that the particular -- first of all, there's very sketchy details about what frailty

adjuster we're talking about.

And second, that at least as I understand the state-of-the-art here, that is ready to actually be trotted out and used. I could be wrong about that, but I haven't heard that case made yet.

Although I agree, as I said before, with Carol that there is some ore to be mined here. I just don't know if this specific -- I'm not comfortable enough with the specifics of what we're doing here to vote for a recommendation.

So at least as this is stated, I would vote against it or I would want to amend it to say let's just take away the extra money and do research on how we would actually do a frailty adjustment. Or maybe we come back in the fall and, with some more details about what we really mean by paying on a frailty adjustment.

DR. NELSON: I'll be brief.

I'm going to try again on page 12, because I want to make sure that our report doesn't mischaracterize Mathematica's evaluation. I could rewrite this based on the date that are there. And since we presumably are judging these based on whether they improve quality.

I could rewrite it to say that instead of there was

no strong evidence of superior quality, to say there was some evidence of superior quality.

The first bullet, the S/HMOs performed better on two measures of preventive services and worse on none.

The second one, there were higher rates of recommended physician visits for two conditions.

And the third bullet, that there were lower avoidable hospitalization rates in the majority of the conditions studied.

The way we've written it, if that's Mathematica's words, then I'm comfortable. But if we are mischaracterizing their evaluation, I think we're vulnerable. That was my point.

MR. GREENE: We're consistent with Mathematica evaluation. Their take on these multiple varied findings is inconsistent results in one field after another and hospitalization is one specific case where we're echoing what they say.

DR. NELSON: If indeed our report says Mathematica concluded that, I'm comfortable.

DR. MILLER: This is a very narrow response to Joe, and I don't know whether we brought this out.

Do you understand that at least CMS feels ready and

has made a proposal to implement the frailty adjuster at the plan level as part of their transition?

DR. NEWHOUSE: I heard that, but I'm just not familiar enough to say I agree with it because I haven't really seen what they're talking about.

MR. GREENE: CMS has made a certain amount of information available. They described their estimation approach, their frailty factors, and so on. They haven't published the literal model but it is there and ready to be implemented.

DR. REISCHAUER: Is the frailty adjustment whether you have more than the average M+C population? You get money if it's more, or you get money if you have any?

MR. GREENE: If you have any -- essentially it processes information on a sample of beneficiaries from the Health Outcomes Survey for the plan, counts the number of ADLs from the survey for each beneficiary, applies a parameter to that count and calculates an average payment impact.

DR. NEWHOUSE: The answer is yes to your question.

DR. REISCHAUER: You get money if you have one frail person, not if your fraction is more than --

MR. GREENE: No, there's no cutoff, but I imagine the

impact would be minimal if you had very tiny numbers.

DR. HARRISON: If you had all people with no ADLs you actually would get a cut. Zero ADLs is a negative number. One to two is a positive number, and then those numbers get larger as you go up to five and six.

DR. REISCHAUER: What I'm saying is how fair is this, especially if it's budget neutral, to the other M+C plans if you're providing an extra payment to a plan that might have below average number of ADLs, a of fraction of total --

DR. HARRISON: As recall, and I don't have it here, I think that if you had an M+C average population, you'd get like 2 or 3 percent, but I'm not positive of that. I think that what you would end up getting.

MR. HACKBARTH: We need to at least try to bring this to a conclusion.

MR. DeBUSK: What kind of money are we talking about here?

MR. HACKBARTH: In terms of dollars?

MR. FEEZOR: 5 percent.

MR. DeBUSK: Of what?

MR. HACKBARTH: It's a 5.3 add-on relative to the M+C rates. This isn't about budget control. This is a pittance in

terms of the amount of Medicare dollars involved.

DR. HARRISON: I think it's $40 million a year.

DR. REISCHAUER: Pete, the answer is less than the foregone earnings that we have used discussing this topic.

[Laughter.]

DR. MILLER: None of this conversation has been motivated by saving money. We are Congressionally mandated to comment on this report. We have to make recommendations about whether to continue this demonstration.

What we've been trying to communicate is the results have been mixed. We don't see a strong argument for continuing with the demonstration. These other discussions are about equity and measurement of frailty, and that's what got us into these other places.

MR. HACKBARTH: Let's put up draft recommendation one. Joe, as I understand what you're saying is --

DR. NEWHOUSE: My problems at the bottom.

MR. HACKBARTH: And you feel so uncertain about the legitimacy, the appropriateness of how this calculation is done, that you would be reluctant to have yourself endorse it, and perhaps the Commission as a whole.

DR. NEWHOUSE: I would normally give CMS the benefit

of the doubt, but I haven't read the regs or the basis behind their recommendation. So I feel like I'm being pushed beyond where I want to be.

I don't want to vote against it for that reason, but as I say, there certainly have been problems in the past with this. I just don't know where we are right now.

MR. HACKBARTH: So if we say we don't know enough about this to endorse it, we can either say well, go ahead with it and express our reservations in the text, or we can say strip it out.

Obviously the consequence of taking it out is fewer dollars available, particularly for the organizations that have frail populations. And that has consequences for the organizations, as well as for the beneficiaries.

So it's a question, in my mind, of where do you want to make your mistake in the face of the uncertainty about the frailty adjustment?

DR. NEWHOUSE: What I'm concerned about is exactly -- I mean, implicit in some of the remarks. If we do it here, we'll be confronted with the other M+C organizations that have a frailer population saying we should have it, too. And that will be a very compelling case then.

I'm not sure we really, the technology is really there.

MR. SMITH: Which is not to call it what it isn't, to call it what it is, and provide for a transition payment above the M+C rate to the existing S/HMOs that would phase down by 2007, at which point we would hope there would be a reliable either frailty incorporated in general risk adjustment or an additional frailty adjuster which passes the test of credibility.

I think Bob suggested something like that quit a while ago.

It would not be fair to these plays to say we're going to take away the 5.3 percent cold turkey in one year. Let's recommend that we phase it out through the period until or in a way that is consistent with a period which will end with the risk adjuster being in place and applied for all M+C.

MR. HACKBARTH: Let me just make sure I understand it and then I want to get a sense of the Commission as a whole.

So as opposed to trying to do this uncertain frailty adjustment, you would just say keep the 5.3 but phase it out over this period. Express support for the concept of a frailty adjustment that hopefully would be generally available in the

period post-2007. Any clarification?

DR. MILLER: That's not inconsistent with the principles that we're using because the second recommendation was the frailty adjuster, if appropriate, for all plans at 2007, assuming they had the time to do the research.

MR. HACKBARTH: The big difference is not in the concept but in saying what the transitional tool is. This proposal uses the 5.3 as the transitional, as opposed to an uncertain frailty adjustment.

DR. WOLTER: Just for clarification, again does a frailty adjuster lead to an incentive to implement proven results? And then secondly, are there going to be frailty adjusters in the fee-for-service program. Is that on anybody's radar screen? Just for clarification, not for discussion, just for clarification.

MR. HACKBARTH: Let me take a stab at it and then maybe Joe can correct me if I'm wrong.

The frailty concept seems to apply more to when you're talking about a package of services and, as opposed to small bundles as we put it. So it wouldn't be a frailty adjuster, per se, for the fee-for-service program. In particular facets of it, we talked about better severity

adjustment for inpatient hospital care and the like. But it's sort of a similar concept but different lingo.

DR. REISCHAUER: Payment for coordination.

MR. HACKBARTH: Payment for coordination is a demonstration idea.

So let me get back to the proposal that's on the table. So it's phase down the 5.3 percent and recommend, express support for the concept of a frailty adjustment to be generally available to all plans post-2007.

How many commissioners like that formulation?

What I'd like to do then is get the staff to draft up something that we can put on the screen. Do you have the technology here to do that? Then right before we adjourn for lunch we'll come back and vote on that recommendation.

Actually, I guess that's a combination of draft recommendation one and two here, so it would all be folded into one.

DR. NEWHOUSE: Maybe we keep two as it is and we just change one to the transition being done from 5.3.

MR. HACKBARTH: Yes.

So I think we're done with this for right now and we'll come back to it right before we adjourn for lunch for the

vote. Of course, that may be about five o'clock, when we adjourn for lunch.

Let's move on to actually the related topic of using incentives to improve quality of care in Medicare. Karen and Sharon, if you will keep in mind the Chairman's plight right now, in terms of timing, I'd appreciate it.

MS. CHENG: This is the final presentation of material for a chapter in MedPAC's June report on using incentives to improve quality.

The first two presentations introduced the concept. In this presentation, we'll focus on the conclusions we drew from the private sector and the recommendations it suggests for MedPAC's demonstration of financial incentives.

Karen will outline implementation issues for incentives and suggest two settings where measure sets may be mature enough to make a demonstration of financial incentives feasible. Finally, we'll discuss ways that Medicare can address quality improvements within two dimensions: within settings and across settings.

On this slide is a brief review. This is the case for why incentives are important. Throughout health care, and Medicare is no exception, payments for health care are not

designed to reward high quality. High quality plans and providers are paid no more than others with lower quality. In fact the system pays more for low quality. For example, when a hospital stay receives a higher reimbursement due to a preventable complication.

In this system, in fact some providers may be especially frustrated if they make the investment in a quality improvement and the savings are accrued by another provider somewhere downstream.

Both private and public purchasers have looked to incentives to improve quality because they provide a means to align the payment with the quality of goals. Incentives can reward those who invest the time and effort in making the improvement. By attaching a real value to quality, incentives may help to foster a culture within plans and providers that encourages their leadership to emphasize quality improvement, recognize contributions throughout the organization toward the quality of care, and reward investment in the information technology that supports clinical decision-making.

Incentives would be only one part of Medicare's current efforts to improve quality. Medicare currently in the role of regulator enforces regulations such as the conditions

of participation to ensure quality. Medicare is also a significant sponsor of research in the quality field. Incentives themselves are not an entirely new concept for Medicare. In fact there already is some use of two types of non-financial incentives: flexible oversight and public disclosure, already in the program. Medicare applies flexible oversight to allow M+C plans who have already achieved high levels on mammography screening, for example, to not undertake one of the additional national quality projects that would otherwise be required.

Medicare also uses public disclosure of quality information for M+C plans, as well as dialysis, SNF, and at the end of this month, home health providers. Medicare has already started to identify and use quality measure sets and develop standardized data collection. It gives feedback to providers and plans regarding their own performance within a number of settings. Through public disclosure and the QIO program, these efforts are keys to building the infrastructure for financial incentives.

Medicare has also become some efforts in the demonstration field. For example, Medicare is testing shared savings to improve care for beneficiaries with chronic

conditions. Physician groups are paid a bonus based on the expected versus actual use of care. Those savings are distributed, in part, based on the quality of care that beneficiaries receive.

So to get an idea of where Medicare could turn next to develop incentives, we look at the private sector. We identified six key types of financial and non-financial incentives, and then we talked to a number of plans, payers, and providers and experts in the field to see what was being used in the private sector, and what lessons had they learned.

A key finding was that one of the most prevalent incentives in the private sector was payment differentials for providers. This incentive works by setting goals for providers or plans and giving a monetary bonus or an additional percentage to those who meet the goals. We identified this incentive as one of the most promising, and Karen will present a draft recommendation of this incentive as Medicare's next step.

Another finding was that provider payment differentials appear to work. Results from Blue Cross-Blue Shield, Buyers Health Care Action Group, and others in regions as diverse as California, New York, Michigan, and Florida have

all been positive. We found that many payment for provider differentials got their start as a negotiating tool. Just as private payers have been approached for increases, so too has Medicare and then Medicare would use similar response in asking for accountability for value in response to higher rates.

However, we heard consistently that the hard part of implementing this kind of incentive is finding the right measures and collecting and analyzing the data to be used to compare providers. These issues must be addressed in addition to others posed by Medicare's size, which is large compared to the private purchasers and plans that we spoke with, and Medicare's population, which is probably more vulnerable than the plans and the payers in the private sector that we spoke with.

Now Karen will pick it up and outline the implementation issues that Medicare will face.

MS. MILGATE: As Sharon noted, some purchasers and plans in the private sector have used provider payment differentials and found them to be effective. Medicare, as the nation's single largest purchaser, could actually lead further efforts to use these incentives to improve quality. However, the program's size, while an advantage, is also a disadvantage

and could create a variety of implementation issues. Identifying, collecting, and analyzing data needed to compare providers is an administratively complex and difficult task. A confounding factor to this is that a wide spectrum of providers participate in Medicare. They participate in different regions, with different populations served. They are very different sizes. A 30-bed hospital would have to be compared, for example, with a 300-bed hospital. And their ability to collect data and commit resources to improvement varies widely.

In addition, with this much focus on specific quality, within specific quality areas, could hinder further quality innovation, taking attention away from other possible important measures. And the evolution of measures would also be important. If CMS were responsible for evolving measure sets, for example, there may need to be broader public input than you might have to have if there was a private sector to evolve to new measures.

Finally, because of the limitations of current case mix adjustment mechanisms, putting in place provider payment differentials could disadvantage providers who take sicker patients. Some providers may actually receive lower scores because they take sicker or more complex patients, not because

they provide lower quality care.

However, there are some potential solutions to these implementation issues and the private sector has used some of them. On this slide we provide some examples of how the choice of measures and payment distribution methodologies may address some of these implementation issues. In some settings where we don't have good risk-adjusted outcome measures one way to address that would be to use process or structural measures such as implementation of a particular type of technology. The private sector has looked at computerized physician order entry, for example, or the types of process measures that are used in the QIO program.

Another way to address some of these implementation issues is to use measures that are already widely used. For example, these would tend to then be less likely to stifle quality innovation because they would be building on efforts that were already underway, so it wouldn't be taking attention away from problems that are already receiving some focus.

In addition, by focusing on widely used measures, it would reduce complexity. You wouldn't have to have a program, develop new measures, a whole new data collection system. Those would already be in place. One way to try to address

some of the issues through the payment distribution mechanism is to apply -- to try to develop your goals so that they're based on improvement rather than a specific attainment goal. In the private sector, most of the time they did actually set: these are the goals we want to reach. You reach them, you get the bonus. If you don't reach them, you don't get the bonus.

However, because Medicare deals with a wider spectrum of providers it may be important to actually look at improvement rather than attainment, or to do some mix so that you're actually making it possible for a wide spectrum of providers to obtain the financial incentives.

Another way to try to address some of these issues is to reward performance on a domain of care, such as diabetes or heart care. Choosing a particular domain of care addresses several of the implementation issues. One is, it addresses administrative complexity because you wouldn't have to develop various matrix of measures. You'd go straight for one condition and not have to have a variety of different types of measures in your measurement toolbox.

In addition, one would suggest that if you chose a domain of care it would probably be on something that would be fairly prevalent, so it would also be able to be measured in a

wide variety of providers, and you would also suggest that this would be building on current private sector efforts so it shouldn't take attention away from important quality problems.

CMS has several initiatives already underway, as Sharon talked about. We believe there are several concrete ways to move forward with provider payment differentials. Given the level of development of measure sets and data collection efforts, we identified two settings where demonstrations tying payment to quality might be most feasible. We believe this because we think that the way the measure sets are developed and already being collected actually address many of the implementation issues.

In Medicare+Choice plans that is already well-established through regulation. There is also a data collection methodology established, and it includes auditing. In addition, the way that measures evolve in the M+C program is actually in the hands of an independent organization, so CMS does not have to take it upon themselves to evolve the measures as they go forward.

In the inpatient rehabilitation facility setting, again, the measures are well established. In this setting we're talking outcomes, risk-adjusted outcomes measures of

functional independence. They're broadly representative of what those organizations do. The main purpose of rehab is to improve functioning, so using functional improvement measures clearly measures what they do.

In addition, there's a standard data collection tool. The inpatient rehabilitation facility patient assessment instrument, the IRFPAI, is actually the basis for these measures. That tool is also used for care management and payment purposes, so it would not create an extra burden on those organizations. The chapter also outlines proposals for how payment could be distributed within these settings in a demonstration project, but we're not going to go through those details at this time.

In other settings, the infrastructure is not so well developed. In hospitals, for example, there are a variety of measures that could be used, but no core set has as yet been identified, and there is no standardized data collection tool. However, there are several efforts already underway in CMS to try to identify core sets. This is also in tandem with other organizations such as JCHO and the National Quality Forum.

But one effort they do have underway in tandem with various private sector groups is their voluntary public

disclosure effort for hospitals. These measures that they are starting to identify for hospitals meet many of the criteria we've talked about in terms of how they would address some of the implementation issues. So through research or demonstration, CMS could evaluate the outcome of this initiative to identify core measures and data collection methodologies for applying payment incentives.

In the physician world, measures are available. However, they're limited to certain conditions. It's often too hard to get enough patients in one condition to get a good enough sample size, and also hard to compare individual physician offices because they take different types of patients. However there are some efforts, even in measuring physician office quality, to try to measure in particular conditions.

For example, there are some private sector initiatives to look at diabetes care and heart condition care in physician offices. And some recent research has shown that as few as 35 cases, at least in one condition diabetes, might be enough to actually characterize the quality of diabetic care for that particular physician.

Another way that the private sector approached

physicians was by focusing on group practices rather than physician offices, and that might be another interesting venue for CMS to begin to look at. And in fact, they actually have a couple of demonstrations where they're trying to look at different ways to pay group practices that are tied to some quality measures, as well.

In addition to focusing on improving care within settings, demonstrations could be designed to use payment differentials to prove care across settings. Because beneficiaries are living longer periods of time with one or more chronic condition, they need ongoing management of their care across settings and also in their home. This is particularly true for the seriously chronically ill and while it is difficult to design incentives based on individual beneficiaries or care for a certain population, Medicare could measure contribution each setting makes to improving this type of care.

I have a couple of examples here and in the paper, but for time I'll just move forward to the draft recommendation.

So in this presentation we summarize what's in the chapter, including issues CMS should consider in designing

demonstrations on provider payment differentials, and at this time we would appreciate your comments on that guidance as well as the recommendation itself.

The draft recommendation reads the Secretary should conduct demonstrations to evaluate provider payment differentials that rewards and improve quality.

DR. NELSON: Would you please, again, say the penultimate question that you wanted us to consider?

MS. MILGATE: We were asking for comments on the guidance that's provided in the chapter to CMS about how to structure demonstrations, some of the ways you could use measures, that kind of thing.

DR. STOWERS: I just had a comment. That's a good chapter. But it was a little bit on the tone of going after the Medicare+Choice and the inpatient rehab. I know they're kind of low-hanging fruit, but I'm not sure it gives appropriate weight to the other vast majority of the Medicare beneficiaries that are going to be left out by the Medicare+Choice, these two very small segment of the population.

I'm afraid if CMS goes after this low-hanging fruit, looking at all the other barriers that we're kind of listing

here, there could be considerable delay in getting after what we all know we need to do, and that's find a way to measure quality in the doctor's offices, in the hospital setting, in these others.

So I really see a greater importance over all to do all of this other lists than to do the list that we're telling them maybe should be the place to start. I don't know if I'm expressing that very well but there's a tone there that we're --

MR. HACKBARTH: Is it just a matter of the tone? Or is it a matter of --

DR. STOWERS: Or of priority.

MR. HACKBARTH: Is a matter of beefing up the language that says these are low-hanging fruit but certainly not the whole of what needs to be accomplished.

DR. STOWERS: Maybe putting a little more important on --

MR. HACKBARTH: Or alternatively, are you saying that if they devote their resources to these two they won't get to the others and therefore you don't want them to do M+C and inpatient rehab?

DR. STOWERS: I just think there needs to be a little

bit more global orientation to the impact of impact of working on these two compared to the impact of working on the larger, more difficult ones.

MR. HACKBARTH: You don't oppose starting with these two, but you really want a strong emphasis that this is just the beginning and not the end.

MS. MILGATE: That's definitely fair. In fact, I meant to talk about that in the setup. So it needs to be a little stronger.

MR. FEEZOR: I know it's late in the morning and I've been a little bit negligent in not getting some of my thoughts back on this earlier, but three quick technical issues and then a statement, I think following up on what Ray was saying about a greater sense of urgency with getting on with the larger Medicare population and expenditures, not just on the areas that we seem to have the most track records.

First is we talk about the public disclosure as being one of the areas and that it enhances consumer choice. I think what is really important is not so much the choice. That's more of a political good you talk about here in Washington. But really is the knowledge and understanding of, in fact, the tremendous variations in quality and of what one actually needs

in terms of health care.

So when we use choice, I think we probably ought to talk about knowledge and understanding perhaps of health care variations and their need.

Second, and I guess I'll ask David if he'll confirm this or not, the reference on the GM efforts to prudent plans, or to create a better performing plan is for salaried employees. I don't think that's for the -- we probably need to make sure that's reflected.

And then the other observation, in sort of the highlighting the innovations going into being done in the private sector, we reference the tiered provider networks in the back end of the chapter but didn't do anything in the front end, as I recall. And I think that's going to be a -- to the extent that some of the tiered networks are trying to, in fact, base it not just on price but on quality, that probably bears a little bit stronger mentioning on the front.

Those are more of the technical observations. I guess as I read this chapter, I thought that we were being extraordinarily tepid at a time where urgency, indeed leadership, needs to be called for.

First off, let me back up. The criteria for the

incentives, I think, were very sound and well laid out. But the fact of the matter is that Medicare currently does use financial incentives, primarily for either higher or lower quantities, either in fee-for-service or in terms of DRG-based.

But I guess I would like to make us a little more sense of urgency that Medicare needs to be moving as rapidly as possible in incentives. And I would say not only incentives that simply impact quality, but the other measures of performance that have been called out by IOM. And that's including not just clinical quality but patient experience, timeliness and efficiency.

I think that I would like to, maybe in a second iteration if we come back to this topic in another year, that certainly we ought to address the question of whether, in fact, that part of CMS's explicit role is, in fact, public disclosure efforts, the information they have and in collaborating with perhaps private initiatives to, in fact, making provider-specific measures more broadly available.

So I'm probably going a little bit rabid here compared to what Ray was comfortable with, but it does emphasize, I think, that we need to begin to go beyond quality to larger performance than, in fact, that we should look to try

to measure that performance or provide collaborative efforts using Medicare data that, in fact, would begin to expose variation in individual performance and that we perhaps make a part of -- at least frame the question of whether or not a role CMS should be helping assist the disclosure of that information.

MR. HACKBARTH: I hear a couple of things, Allen. One is stronger language, language infused with more urgency. A second might be, I guess, even cast as a recommendation that CMS pursue provider-specific disclosure, which is something that from time to time has been controversial and they probably would welcome explicit support for that.

MR. FEEZOR: And I think the third thing, and maybe we can back into it by when you highlight what I think is trying to be done in certainly some of the private sector measures, it's not just quality improvement. It really is performance of the health care delivery system on a variety of factors and particularly those that were called out in the IOM report.

MR. HACKBARTH: What do you think about having an explicit recommendation? Recommendation doesn't quite seem the right word, but an explicit expression of support for release

of provider-specific quality information? Reactions to that?

DR. NEWHOUSE: To paraphrase Orwell, some providers are more equal than others. I'm not persuaded, based on the literature, that this makes sense at the individual physician level. But I think it makes sense for the institutional providers.

MR. HACKBARTH: Any other thoughts on that?

DR. WOLTER: I think it's already planned. JAMA just published state-wide data. My understanding is that those indicators, many of which do sync up with the IOM recommendations and what not, will at the institutional level be coming along in terms of public disclosure in the next year or two. I totally agree with it. I just think it's in the works.

MR. HACKBARTH: It's planned, but the history of this, in which I've had a personal part, is that it happens and then political resistance grows to it and then it sort of retreats for a while. Maybe it would be helpful if we had some explicit endorsement of that as a strategy for the long-term.

I agree with Joe's caveat about we're talking about institutional providers at this point, as opposed to individual clinicians, which I think is a vastly more complex area.

MS. DePARLE: I wanted to endorse what Allen said. I guess I feel rabid, too. I thought the background work in this chapter was very good and very comprehensive, a little too detached and I think that we should play a leadership role. I think that the administrator of CMS, Tom Scully, and the team there are really trying to do a lot of things to advance the cause of providing more information to the public and to providers, which I think will help to raise the quality bar and hopefully lower some of the preventable medical errors that the IOM report highlighted. We should have an explicit recommendation that supports what their doing.

DR. WAKEFIELD: I concur with what's been said to this point and also say, Nick, if people took a look at that JAMA article and the voted with their feet, a lot of folks would be seeking health care in North Dakota. I just want to point that out. When you look at those state rankings, we're right at the top.

Having said that, -- all the Lutherans, yes. Good high quality Lutheran care. I'm not one.

What I did want to say is in just in terms of tone, I want to reiterate -- although Ray made the point. As I was reading through this chapter, I was thinking gosh, I'm going to

get to a recommendation that's going to have embedded within it M+C and rehab. So I saw that disconnect, too, as I was reading. I just want to reinforce that in that tone.

Secondly, I really like the inclusion, of course, of private sector efforts to date. I did wonder if we couldn't get a little bit more of a nod, and I would defer to other people more expert in this than I am, that's for sure, a stronger mention of public sector efforts in the sense of what the QIOs have been doing.

For example, in their current scope of work, I think they've got fairly widely accepted indicators of CHF, MIs, pneumonia, and surgical infections. I think the health care community, there's pretty good buy-in. I think there's pretty good data. And that hospitals that want to set up processes to implement efforts to achieve high-performance around those four areas can be helped by QIOs to do that, for example.

So I was just wondering if we might be giving a little bit of short shrift to what is there. Good reference to private sector but maybe a little but more of a nod to what's also occurring frankly through CMS' own good work.

Then I would just say, and I haven't settled in on any particular place on this yet, that those quality

indicators, as I was thinking about them, they probably should be done, based on what I just said, about 100 percent of the time rather than improving to the 80th percent or ratcheting up. If there are good data and we feel pretty confident about what their measuring, you'd almost think gee, everybody should be doing them all of the time.

But having said that, I did wonder if there couldn't be or should be a little language in the text about maybe that's an area to pilot around too, those quality indicators.

So if we're looking at trying to incent performance maybe we look right at what is already coming out of the seventh scope of work in addition to -- and I'm not suggesting another recommendation. I'm just saying maybe in the text we can give a little but more of a nod to that effort, pulling that out just a little bit more.

If you find that what I just said is, in fact, the case.

MS. MILGATE: Yes, just a quick note. The measures that are part of the voluntary public disclosure that I referenced are actually derived from that. So we could certainly make that link more direct. But in fact, that's sort of what -- yes.

DR. WAKEFIELD: If you can make that more directed that would be great.

MR. DeBUSK: First of all, that was an excellent job on this chapter. This is certainly something that's certainly super important, important going forward.

In the potential solutions, as you can imagine, I was sure glad to see you say something about process and structure, after the last meeting.

In the first steps in other settings you talk about hospitals and physicians. And I noticed in the conclusion here, it says however, providing incentives for providers to improve care may also be a way of beginning to address concerns about variations in practice patterns.

Ultimately, as we go forward with best practice models and protocols, that's going to become a big issue. I'd love to see something more said about that in the text, because ultimately we've got to deal with that. And there is a wide variation across this country.

MR. SMITH: Karen, Sharon, I thought this chapter was extremely well done and I was rapid after I read it, so I thought it did a pretty good job of inciting, as it should have.

A question about the recommendation. Why just payment differentials? Why not beneficiary savings differentials? Several of the more interesting examples use that route. We don't talk about it.

MR. HACKBARTH: I was the one, David, who took us down that route, I think at the last meeting. The reason that I thought this was the higher priority, provider payment differentials were the higher priorities because of the confounding influence of supplemental coverage for the Medicare population.

MR. SMITH: I agree with that, Glenn. I didn't think that was an argument for not exploring ways that co-payments might be used, borrowing a little bit from the GM experience.

Along the same lines, did I understand correctly that we wanted to add disclosure to this recommendation? Or do we want a separate recommendation?

MR. HACKBARTH: I was thinking in terms of a second recommendation, myself.

DR. REISCHAUER: I might not have many sympathizers with this point but I thought there was sort of a disconnect between some introductory sentences and the chapter as a whole. I'm just going to read one, which is Medicare has a strong

commitment to quality demonstrated by its many efforts to measure and improvement it.

I think, quite frankly, historically it's been an embarrassment. This isn't to say that people at CMS haven't been concerned but this is a huge chunk of our health care system which lags behind both where private industry is and where states are. And it's in the basic structure of the program really, in that it is basically an all-willing provider kind of system and it does have as its board of directors the Congress of the United States, and it does serve disparate geographic areas. And that, by and large, those factors have kept it from being where it should be, which is at the forefront of the drive to improve quality for a particularly vulnerable and important component of our population.

I'd just like some recognition of that. If this sentence was right, it's sort of like why are you reading a 30 page chapter to pat them on the back?

The other thing that I would like us to emphasize a little bit more is I think this obviously can be done in bits and pieces and because of the way we have our payment system it really would not be hard to adjust the payment for one DRG here or there in the computer based on these kinds of things, and

that we should, as Ray and Mary say, want to go ahead as rapidly as possible even if it were just in small areas for this.

Finally, you mentioned that there was sort of the trade-off between the levels and the improvement, how do you do this. There is the way around this dilemma and that is to have rising thresholds. That you start very low. You say if you achieve this level in year one you get the extra payment or you don't get the reduced payment.

But that level rises at 10 percentage points a year up to the threshold that you want to be at. Sure, it doesn't have a lot of impact at the beginning except that it wakes people up, but it gives those that are poor performers an opportunity, and it reduces the political resistance to this because everybody would assume that certainly they can make it by 2008, or whatever, when you're going to reach that threshold that clinically you probably should be at today.

MR. HACKBARTH: Let me connect Bob's comment to what I heard Allen and some others saying about conveying a stronger sense of urgency.

I think the point is that there is a long history, but we don't have enough progress to show for that long

history. That's because there is perhaps constancy in terms of lip service being paid to it, but the level of commitment to action has been, at best, very uneven over the last 20 years, 15 years. So like Bob, I wouldn't want in our --

DR. REISCHAUER: 37 years.

MR. HACKBARTH: 37 years. I wouldn't want our preface acknowledging this long history to be interpreted as oh boy, this has been good stuff all these years. We really don't have what we should have, and we need to step it up and get more results.

MR. MULLER: I share both the sense that the recommendation should express some more urgency. But also, given the various efforts that have passed as efforts towards quality improvement, I would recommend we be a little bit more specific and I think this chapter does a very good job of pointing out some of the things that have worked better than others. I think it's just been too easy to call almost anything anybody does an effort towards quality, which therefore goes to Bob's comment that we kind of pass our hands over the stuff and say it's all quality efforts, and they're really not.

So I think getting more specific based on some of the

very successful things that are in the chapter or adding on Mary's QIO, but I think that would help that, given that we spend a lot of time on Medicare, putting our voice and saying some of these initiatives make more sense I think would add some credibility to it.

Everybody else has already said it, so no use beating on these words any more. It's just not urgent enough. And therefore, putting a few e.g.'s in there, I think, would be quite helpful. I'd be glad to recommend which ones they are, but two or three, I think, would be helpful.

DR. NELSON: Balancing off the caveats of the difficulties of physician performance measurement can be some information about the Physician Consortium for Performance Improvement which was convened by the AMA and represents the major specialties that has developed or is developing performance measures for diabetes, coronary disease, heart failure, hypertension osteoarthritis, major depressive disorder, prenatal testing, preventive care and screening for mammograms, influenza, tobacco, colorectal cancer screening, problem drinking, asthma and community-acquired pneumonia.

So a constructive effort to develop the performance measures with the clear implication that there is an

acknowledgement of this ultimately being incorporated into physician measurement.

MR. DURENBERGER: I've shared a lot of thoughts with Karen and the staff, and I really am so grateful for the opportunity to be able to do that between meetings. It is really very helpful.

I agree with what Ralph said about, I raised the last time, about PRO, there's a history here. Which leads me to the fact that most of the history was aimed, starting with the prospective payment system, at underused, the danger of underuse. And if we accept underuse, overuse, and misuse as some of our definition, a lot of our history was sort of guarding against some of the problems when we don't have the right incentives in the payment system.

I went to my first board meeting of NCQA a couple of weeks ago and found out that, next to consumer-driven health care, quality is sort of like the business buzz word, and everybody is getting into it, every specialty association is going to identify it.

Which for me just fortifies what I've heard around the table here today, which is why it's so critical that Medicare set the pace. And that we, in whatever we say to our

friends on the Hill, help them set the pace. I won't belabor why but I do want to thank Nancy-Ann, as I've done before, and now Tom Scully, because I think they really have -- to the degree that this has to be acknowledged I'm not sure it's necessarily all that important.

But I really honest to God do believe that the leadership in HCFA and CMS has been trying to deal with this problem. And I don't know that this paper gives them adequate credit for that because it relies heavily on privates do better than publics and so forth. And that isn't always necessarily the case.

Point number two, though, deals with the specifics. The comments in here tend to reflect that it's nice what CMS is doing, but they're not doing the ideal, which would be payment differential. And someone has said this before, that I think to get to a culture of quality you're not going to do it one person at a time. You're going to do it one community of practitioners at a time. And that might be a multi-specialty group or it might be a city or some other community or something like that.

But the notion that somehow or other we're going to get there -- and I'm not saying that in the end payment

differentials aren't critical and so forth. If you want to talk about incentives, the best place to go is to go to a group of physicians and/or other health professions. Some kind of an integrated system is always preferable. You can see its there already.

But the concept of culture of quality can be built best by changing the practice. And the best way to change the practice is if the doctors change it themselves because they're getting rewarded for doing it. Rather than having the public or CMS say this doctor gets so many dollars and that one doesn't, which leads to the political problems that Bob talked about last time, doctors themselves discipline the system. They work the changes that take place within the practice.

So I think it's simply the way this is presented. It isn't like pay differentials is better than what Tom Scully's trying to do right now, because I think what he's trying to do right now, as I see it at least, is to take groups like the 200 docs or more group or 200 docs or less group, I don't know what he's doing.

I think he's trying to take these larger groups and provide them with the incentive. Minnesota has an application to take the whole state as a demonstration. The idea is to

build the incentives into this community of doctors to change the way we do it and let them keep some of the savings that come from it. That's the incentives part.

I was hoping, in the way we talk about this, that we don't say that doctor by doctor differentials, insofar as it's implied that language, is preferable to what the CMS is currently working on which is, in the larger groups and so forth, but at least maybe equate them and say whatever you want about the payment differential.

DR. WOLTER: I just want to underscore my belief in the importance of what Dave just said. I think that differentials based on the current payment system is one thing, but changing the way we pay to decrease the fragmentation of the current health care delivery system is the critical transformation that has to happen in the system. It would be nice to be able to talk about that in this chapter.

I think differentials have their place, but we've talked about Part A and Part B. We need to put some things in place that create teams of people delivering care in a important effective manner. The current system really, in many ways, creates barriers to that. That's why I don't really favor highlighting Medicare+Choice, by the way. I think it

belongs on the list, and for what I just said I can see why you might choose that as a place to highlight, but I think that if we're going to make headway really, and if this is urgent, we need payment mechanisms that really create bringing people together to deliver care.

If we could get into that, to some degree, in this chapter I think it would be very important.

MR. HACKBARTH: There are some places in the chapter, and perhaps they need to be beefed up or reworded a bit. But I can think of a few places in there that refer to how central that concept is. I agree.

MS. RAPHAEL: I was just going to follow up on that because I think what we're doing is deriving our recommendation from the private sector and what's workable in the private sector. And where we have good measures. Those are sort of the two pillars that we're building our recommendation on.

You could also say part of the criteria should be where are beneficiaries experiencing the most problems in terms of care? I think where beneficiaries experience the most problems is in the lack of continuity between a primary doc and a specialist, the hand-off between the hospital and the place the person is going to afterwards. That's another valid

criteria that should determine where you focus your experimentation and efforts.

I agree with what Nick just said. I think we need to think about some experiment that would deal with the continuity index which is in this chapter. The other, I think, really powerful area that we have to deal with is the current disincentives, that if you make an improvement in your domain, in your silo of the world, it could really affect the Medicare program in another silo that doesn't accrue to you. Some of the things you could you could reduce admissions to hospitals so your disincented from doing it.

So I would somehow like to see something, even in a recommendation, that would take us maybe one step beyond this in experimentation.

MR. HACKBARTH: What's tricky here is that we have two, at least two purposes, in this chapter. One is to present some conceptual thinking about how quality might be improved. And all of the recent discussion I fully agree with. Probably the greatest opportunities are in terms of integrating the care, improving the hand-offs, thinking in terms of teams as opposed to individual providers. I emphasize how strongly I agree with that.

The other purpose though of the chapter is to try to continue to create some momentum so we're looking for what can done in the short run. The trick is to write this in a way so that it's clear to the reader that by endorsing some specific short-term steps -- that's not to say that they are as important or more important than the long run, but we want to create some momentum. Some things need to get done, even while we continue to look for much more important opportunities in the areas just described.

In fact, it may be good early on in the chapter, to about how we have two purposes here. One is to advance the broader, longer-term cause. But second create the sense of urgency to begin moving ahead in the areas with the greatest short-term possibility.

DR. WAKEFIELD: Even the wording of that recommendation, I think Glenn, does not diminish what you just said. I could take that concept and think about this recommendation moving both the long-term issue forward as well as the short-term. So I think they could write this chapter in a way that CMS could see that recommendation and think it could easily apply to both of these issues, a coordinated continuum of care side as well as this more --

MR. HACKBARTH: I can see how Nick or Dave or Carol might be concerned, if we have readers that just look at the bold-faced printed and they look at this, their message is lost. All they see is evaluate provider payment differentials.

MS. MILGATE: What if we said within and across settings? Does that help?

MR. HACKBARTH: I'm not sure, without making the bold-faced print run for a page, that we're going to be able to capture all of the nuances here.

DR. WOLTER: We could say something like payment differentials and mechanisms, to imply that case management or emerging Part A and B or other --

MR. HACKBARTH: What I had thought of was this particular recommendation was a low-hanging fruit recommendation. It was to say there's a whole lot of stuff going on in Medicare demonstrations, in the private sector. Right now we think provider payment differentials are the greatest short-term possibility.

Maybe what we need to do is have a separate recommendation that says, in the longer-term the greater opportunities are not looking at individual providers, but more systematically at the patterns of care and how providers relate

to one another.

MR. MULLER: I think that captures what I was trying to say, which is we've had the effort where M+C hasn't taken off as much as people thought it might, and we still have fee-for-service in the bulk of the program. But as a number of people said, the fee-for-service system really makes some of this coordination very difficult. So I think we need to experiment whether the mechanism word is sufficient. But we also need to experiment with some systems of payment that go beyond fee-for-service, that don't necessarily mean to get everybody back into thinking that the only alternative is M+C. But some systems of payment that promote and encourage innovative care to go forth that enhances quality.

DR. REISCHAUER: This might argue for taking a big chunk of the CABG discussion and putting it in this chapter, because that's exactly what that was.

MS. MILGATE: Sure.

MR. HACKBARTH: We're running out of time here.

MR. DURENBERGER: I know you want to quit.

I think the problem, as I follow this discussion, is that we come very specifically and say Medicare+Choice plans are the place to start. If I took you to InterMountain, I'd

take you to Marshfield in Wisconsin, I'd take you to a lot of places like that. I'd start there before I'd start with the Medicare+Choice plans because they've got the data, they've got all the information.

It's the exclusion of existing practitioners who have been leading the way on quality from our recommendations as to where to start that I have a problem with. I don't know how you want to deal with that one, but there are a lot of really good examples in America today, we heard from some of them a few months ago, that ought to be places we start, as well.

MR. HACKBARTH: Let me try to use that comment to really sharpen the issue. InterMountain Health Care, I used to work for InterMountain Health Care. I think great things.

But when you focus on what they're doing, you're not talking about a systemic effect in the program. Whereas, if you take M+C here, albeit it a small piece of the program, you're saying here's something that affects all of this little box within Medicare. It's not an isolated provider demonstration, but moving to implementation of a set of measures that affect a piece of the program.

In fact, in some ways this goes back to our earlier discussion. There's two tracks here. One is program

implementation, the other is demonstration. I think there's a lot of important demonstration and research work to do with people like IHC. But right now there's an opportunity to implement something as a part of the program with M+C and inpatient rehab.

One is not better than the other. We need to move on both is the message that I hope will come through. Is that consistent with what you're saying? Or would you rather just drop M+C and do provider-specific demonstrations?

MR. DURENBERGER: No, this is why I said earlier either complementing Medicare rather than saying there's something better than what they're doing, but recognizing in the specific what CMS is currently doing with provider groups. Adding that to the Medicare+Choice.

I just don't like to see Medicare -- maybe I don't know enough about Medicare+Choice, but we're going to get more in the long run for systemic change by going to Medicare+Choice than we would get by using the current demos along with is, I guess, where I'm at. Not that we're deciding anything anyway.

DR. MILLER: Just a couple quick things.

By way of editorial, I imagine Karen is feeling the same way I am right now, that none of this chapter was intended

to somehow imply that what CMS was doing wasn't good. In fact, we had very explicit conversations about putting sentences in that said this is a good thing.

So we must need to pump that up more because it's certainly what we think, and QIO and all the rest of that.

The other thing, and I'll take some responsibility for this if not all, depending on how it plays here. I was trying to push Karen and company to say let's talk about concrete things that they can do, places where we think the infrastructure and the information -- largely because of CMS's efforts -- is already in place and they could quickly move on it.

I don't think any of our views are M+C is the place that you have to go, or any of our views are that you couldn't pick up a group and pull them into these kinds of payment differentials to look either at coordinated care or some of the activities of the groups that you're talking about. We must not have gotten the words quite right because you're not saying anything that's inconsistent with where we're going.

But we didn't want a chapter recommendation that just sort of said oh, you should do more quality stuff. We were trying to say here is the areas that we think have some

promise, to point in their direction a little bit.

MR. DURENBERGER: Maybe I was reacting sort of small p politically, with is somebody like AAHP sees that recommendation, it's a source of new money, let's start focusing on Medicare+Choice, takes it away from something else that the administrator believes might have an equal amount of payoff. So it's that sort of instinct that may have misled me.

But as long as we're comprehensive in our recommendation.

MR. MULLER: I'll go back to my e.g. example and what we discussed both in today's whole morning and in prior sessions, some of the things that we think can relate to quality, disease management, case management, bundled payments, and then some of the other examples in here.

So I would like to highlight some of those as things we should experiment with to be more specific about what provider payment differentials and mechanisms mean.

DR. WOLTER: Glenn, I think what we're saying is that maybe there should be just equal billing. Just as one concrete example, in the S/HMOs, the quality results that we're seeing came out of the group practices, not out of the looser network part of the plan.

I just think that there's an infrastructure in place. It's not a longer-term. It could be as short-term as looking at Medicare+Choice. It's not to take Medicare+Choice off, I don't think it's an either/or at all. It's equal billing.

MR. HACKBARTH: Let me ask you then, Nick, as the last one to speak, to make a specific proposal that you would like the Commission to consider. If we've got one recommendation.

DR. WOLTER: What I would do is just in the text not have Medicare+Choice jump out as the place to start, but to certainly highlight it as a place where good work can be done. But also, we should be looking in this other areas which, as you pointed out, are already in the text and could be moved up a bit.

And then we might slightly modify that recommendation so that it also includes other ways of a payment being put in place to increase coordination of care, differentials and other innovative mechanisms, something that.

MR. HACKBARTH: Are you going to suggest something specific?

DR. NEWHOUSE: I'm going to respond to Nick. The mechanisms didn't do a lot for me when you said it. But I'm

wondering if you really mean more aggregated payments or bundled payments or something of that nature. Maybe the text just spells it out. But is that what you mean?

DR. WOLTER: Actually, I mean a long list of things and I know we're running out of time. But it could be more bundled payments. It could be better payment for case management. It could be payment for e-mail care. It could be better payment for using technology to take care patients in their homes.

I mean, we've been given a list by some of the people who came before us in the last few months. There's a lot of innovation in some of these ideas. And I would think we would want the demonstrations to include some of those things.

MS. MILGATE: Just a reaction to that, one of the basic assumptions that we did make -- it doesn't mean that we can't talk about it, and it might be good to set it aside because it sounds like folks are having trouble with that assumption -- was we tried to look to the extent we could at something to build on the current payment system because taking on changing the whole payment system seemed a little bit larger than we wanted to handle, particularly from what we found in the private sector. Although that wasn't our bias in the

beginning, I would say.

But I don't think that means that we couldn't discuss that there are many other ways that you could look at changing payment, and here's a list of what those things might be.

DR. WOLTER: I think it's just a bias. I think what some people in this room are saying is maybe it's time to express urgency, to be a little bolder, and to suggest that more out of the box thinking. It's not something we should wait 10 years to get to. That would certainly be my bias.

DR. NEWHOUSE: I think the problem, I'm with Glen on the shorter-term, longer-term thing. The problem is in the shorter term you don't want to put something in nationally that you haven't seen before. The downside is just too big.

So it seems to me that the stuff we haven't much experience with we probably would want to go a demonstration route in the shorter run.

Well that's fine, I think that's the sense then. In the shorter run we could do M+C and inpatient rehab. And we could do demonstrations elsewhere.

MR. HACKBARTH: And emphasize in the text that the fact that the M+C and inpatient rehab are coming first is not a statement about their importance but rather their ripeness, and

that the real gain -- I'm the truest of true believers in terms of what you're saying, Nick. The biggest long-term gain is in these more systematic approaches to integrating care and looking across individual providers.

The text language is obviously, in some ways, the easiest part because it gets it off the table for right now and we can all look at the draft language once it's circulated. The piece that we need to deal with right now is whether we alter this draft recommendation language.

And what I hear is Nick expressing a strong preference to adding some reference to coordinated care in some form in a demonstration mode.

DR. MILLER: Right. For example, on this recommendation, if you were to add words after the payment differential and say something like and other -- you could use the word coordinated care delivery systems or comprehensive care delivery systems -- and just put it in after the word differential. You've got both demonstrations, payment differentials, and that this concept then Nick is talking about. Does that reach it?

MR. HACKBARTH: Say it one more time.

DR. MILLER: It would read just like it does up to

payment differentials, and then would say something like and other coordinated care delivery systems that reward and improve quality. It's just putting a clause in after differential and before that.

DR. REISCHAUER: In a way, coordinated care is too narrow.

MR. HACKBARTH: Let me establish a ground rule, when you grab the microphone now, the requirement is that you propose an alternative if you don't like it.

DR. NELSON: I hate to disagree with Nick because I think his concept should be dealt with clearly and firmly in the text. But I think this covers it. This chapter is talking about payment differentials. And I think that this provides latitude for a variety of mechanisms.

So my alternative is to stick with that recommendation.

DR. REISCHAUER: What about saying payment differentials and structures? Because what you're talking about is different payment structures.

MR. MULLER: Those words, by themselves, would not capture this discussion over the last hour. So if the people only read those recommendations, they wouldn't capture what

we've spent our time trying to come to some agreement on, which also reflects six months of discussions.

So I would like to add some words that capture -- I like Bob's differential payment and structures and collective mechanisms. I'll work on the words, but I think something along those lines.

MR. HACKBARTH: Do you want to say it one more time, Bob? You're making the motion here.

DR. REISCHAUER: The question was whether I was going to accept the senator from Pennsylvania now.

MR. HACKBARTH: Make a proposal. We need to get this done.

DR. REISCHAUER: Payment differentials, structures and -- Ralph? Differentials, structures, and --

MR. MULLER: Collective care and care coordination.

DR. WAKEFIELD: I have a question about that.

MR. HACKBARTH: Are you going to suggest an alternative?

DR. WAKEFIELD: I'm going to raise a question. I need an interpretation of that. Because what that rephrasing says to me is we have just delinked a payment incentive from structures and collective whatever --

DR. REISCHAUER: You know, I think in a way structures encompasses what you're talking about.

DR. WAKEFIELD: But I'm saying is it we're going to evaluate provider payment differentials, structures, and something else? Or are we using payment incentive to reward and improve quality, and those different models could be different structures, collective whatever organizations we were talking about a minute ago?

All I'm saying is are you delinking the payment driver her and saying it's okay if they evaluate different types of systems of care? And do we want to do that?

I thought we were using the payment differential as the driver and that different models could be put on the table that would be designed to reward, that would be designed to achieve quality improvement. It's in the wording of that that I'm expressing concern.

MR. MULLER: We had the clause in the wrong place. I think we agree that we want payment differentials. What we're trying to capture is that there's some consensus as to the kind of things we should be experimenting with.

MS. ROSENBLATT: How about differentials, structures and models that...

MR. HACKBARTH: Conduct demonstrations to evaluate provider payment.

DR. WOLTER: Glenn, I'm sorry I got us into this mess, honestly. I was actually trying to be very specific to payment. And my original point was differentials is one thing, other models of payment or other structures of payment, not the structures of care, could be part of what we do. So I actually think Bob's recommendation handles it. And we cover the models of care in the chapter.

DR. NEWHOUSE: How about provider payment methods?

DR. REISCHAUER: It sounds too much like it's taking the existing payment structure and you can go up or down, that kind of thing. This is sort of a different --

DR. NEWHOUSE: How about provider payment methods? It gets us out of -- differentials seems narrow.

MR. HACKBARTH: The other alternative here is, rather than trying to cram it into one sentence, we could have two. One would be to do demonstrations to evaluate payment differentials to reward and improve quality. In addition, demonstrations should be done of payment mechanisms that reward better coordination and integration of care.

MR. SMITH: I think Nick and Mary are right about

that. What we want to do is use payment differentials and payment structures to reward improved quality. Those payment differentials or payment structures might provide additional payment for precisely what Nick's talking about.

But we want to make this about the payment system. We don't want to make this about several things. We want to use the payment system to get the kind of structures that produce the kind of quality outcomes that Medicare ought to be aiming for.

So I think if the sentence reads payment differentials and payment structures, or maybe even just payment differentials and structures. So we're talking about payment structures not organizational structures. I think we then capture this conversation.

MR. HACKBARTH: The language on the table is payment differentials and payment structures, or payment differentials and structures that reward and improve quality. All those opposed? If you dare. All those in favor? Abstain?

We're going to modify the agenda here to a bit because of our running over. We are going to take the piece on the CMS letter, on the update for physician services, and move that to after lunch. I am hopeful that that's going to be a

very quick item. In fact, it's going to need to be because Kevin needs to leave. So we'll do that after lunch.

Before we leave for lunch, we need to vote on our revised S/HMO recommendation. While I'm thinking of it, before we turn to the recommendation, just so I don't forget -- oh, this really is just logistics. We're going to have lunch in a different room. We'll handle that once we adjourn.

Let's go to the S/HMO recommendation. Do you have anything you want to say, Tim or Scott?

MR. GREENE: This is a modification of the recommendation you saw earlier. We address Joe's concern about the frailty adjustment modeling and proposal that was built into the previous one.

Here we simply phase out the 5.3 percent S/HMO add-on on the same schedule that CMS is using, the statutory schedule for implementing risk-adjustment in the Medicare+Choice program.

MR. HACKBARTH: Unstated here is that concurrently we phase in the risk adjustment for the S/HMOs just as it's being phased in for all of the other M+C plans.

MR. GREENE: I'll show you. This would be the schedule and this is the existing schedule, M+C schedule. In

the first year 2004, 70 percent of the 5.3 percent would represent 70 percent of payment and risk adjustment 30 percent. The 5.3 percent add-on is reduced to 50 percent the next year. And by 2007 these plans would be treated as other M+C plans would be, they'd be paid under M+C risk adjustment, without any frailty add-on or any such factor.

MR. MULLER: We still have recommendation two, or was this meant to absorb two?

DR. HARRISON: You would also have two.

DR. NEWHOUSE: Two encourages research on frailty.

MR. HACKBARTH: Rather than having you try to flip back and forth, just leave the one up. People can look at the packet that they have in front of them for the language of number two. Just put up your alternative one.

All opposed to the revised alternative? All in favor? Abstain?

And then number two in the packet, has everybody found that?

All opposed to recommendation two? All in favor? Abstain?

Do you need another minute?

MS. DePARLE: I'm sorry, I found it. I would like to

vote in favor of that.

MR. HACKBARTH: Let's just, for the record, do that vote one more time. Has everybody seen it now, recommendation two?

All opposed? All in favor? Abstain?

Okay. I think we're done. Thank you

We'll have a no more than 10 minute public comment period with the usual conditions. Brief statements are more effective. And if you're going to repeat what somebody has said before you, just say I agree with that. Otherwise, you'll run the risk that I'll cut you off, if I hear you repeating.

Yes, sir.

MR. CLENDENAN: Good afternoon, Mr. Chairman, and members of the Commission. My name is Peter Clendenan. I am the Executive Vice President of the National Association for the Support of Long-Term Care. I'm here specifically to address recommendation one with respect to competitive bidding for durable medical equipment.

Our organization represents non-profit organizations and for-public organizations to supply ancillary services and products to long-term care and home health facilities.

Accordingly, our members provide durable medical

equipment, disposable supplies, specialized therapies, physical, occupational, and speech therapy, as well as lab, x-ray, software, and other services.

We're actively engaged with both MedPAC and CMS in a series of cost containment procedures and we see competitive bidding as simply one more layer on a series of layers to cost contain. Specifically, we've worked with CMS on inherent reasonableness, as well as on consolidated billing.

Our point today to you would be competitive bidding is one more layer on a relatively confusing set of other cost containment procedures. I would urge you to reconsider the action you took with respect to recommendation one on competitive bidding. We would urge you to let the existing cost containment procedures work before you add another layer of complexity to Medicare reimbursement.

Thank you.

MR. FORD: Hello, my name is Tim Ford. I am from Elder Plan, one of the social HMOs based in Brooklyn, New York.

I just want to speak on behalf of the S/HMO model and the actions that you have taken today. I will be brief.

I just want to say that the S/HMOs, I believe, have earned the right to permanency. And I think CMS, through the

risk-adjusted payment system, did lay out a framework to achieve this under a different payment model, which I think refutes a lot of what was -- or I won't say refute, but corrects a lot of the impression that was in your report to Congress which Senator Lott, on the issues that we were overpaid.

The second thing I want to say is that the proposal that I believe, if I understand it correctly, that you've recommended does not, in fact, give us the frailty adjuster through 2007, as was laid out by CMS, and actually reduces our current payment system over that seven year period.

If I understand that correctly, that will be very damaging to our members. What I think maybe you don't understand, you think of that as a 5.3 percent add-on that comes for all of your payment. But that payment is actually directed towards people that are determined to be nursing home certifiable.

In the case of Elder Plan, we have members that are nursing home certifiable that, with that eligibility are recipients of expanded benefits. In our case, specifically up to $7,800 of community long-term care benefits.

Those benefits are very important for keeping them

out of nursing homes. I can tell you that when the payment is taken away from us, we will have to seriously address whether we could continue to provide those benefits. It would be very difficult to do that. So a disproportionate share of our membership will receive the impact of that.

The second thing is, I'm not sure if the whole group actually understood the frailty adjuster and how that was developed. But just to do it in about a minute, the way the frailty adjuster was is they took population and ran it through the 66 condition model for the fee-for-service population base for that. They looked at what was unexplained, what cost was unexplained after running the 66 condition model, took that residual, and modeled how to correct, using ADLs to correct payment for the rest of that.

And that's something that wasn't done uniquely for the social HMOs but it was the approach they're taking for all the specialty plans.

And the determination of whether your population is frail and not frail comes form the Health of Seniors Survey, which is a survey of 1,000 of your members. And they return the surveys, that records their ADLs. And then, based upon your distribution within the 48 ADL groups they lay out, that

becomes your ADL adjuster. So there is a rationale to that that I think is grounded in some solid work.

Lastly, on the issue of do the S/HMOs provide value benefits to their members. The reports to Congress could not find definitive evidence that they did, or certainly that was the comment of many.

However, I think it's also correct to say that they did not find evidence that they did not. In fact, both reports pointed out a number of things that they did well in terms of targeting resources to the frail, care management programs and initiatives, risk screening and decreased hospitalization of at-risk populations and others.

In context, there's really few evaluations in health care that are definitive and dramatic on their own in a single study. And that's why in health services research there usually are multiple studies conducted and results must be replicated.

Yet in the case of the S/HMOs, they really have not even been the recipient of even one well-designed evaluation over the 18 years that they've really been in existence. In fact, over those years, the notion of what they were intended to achieve has even changed. Originally designed to integrate

long-term care services into the medical model in order to avoid nursing home placement, they were later evaluated based upon their ability to provide unique geriatric focused models of care.

The former, the ability of whether we are keeping people out of the nursing homes, has still never been studied. There's never been -- if you look in the reports to Congress, you'll see no comment on that.

And the latter, about the geriatric focus, really became the basis for the S/HMO II. And that study is still underway. The report to Congress was really based upon 22 months of study but that didn't necessarily mean 22 months of interventions that have been in place during that whole period. So that's really continuing.

So one thing we would say is that the S/HMOs would continue to contend that their true value cannot be evaluated until the targeted outcomes are more clearly stated, and better studies are designed and implemented and the plans are given ample time during that evaluation to demonstrate their impact.

My final remark is to say that I think it's in the best interest of CMS for its beneficiaries and for its planning and its programs to encourage innovation and not to discourage

experimentation. I think what you proposed actually goes a step back away from that.

What I think we do need is better evaluations so that we can focus, not just passing judgment on the programs but what they do well and what they don't do well, so we can learn from those and integrate those into the models of care that we provide for our Medicare beneficiaries.

Thank you.

MS. FOSTER: Good afternoon, thank you for this time. I'm Nancy Foster with the American Hospital Association.

I wanted to express, on behalf of the 5,000 hospitals and health systems that we represent, our appreciation for your discussion this afternoon of the issue of quality and ways in which we can promote quality through better payment or better structures, as you have come to the language.

I wanted to make sure that you were aware of an initiative that we have launched in collaboration with the Federation of American Hospitals and the Association of American Medical Colleges and with significant and substantive support from CMS, the Agency for Health Care Research and Quality, the Joint Commission on Accreditation of Health Care Organizations, the National Quality Forum, the AARP, and the

AFL-CIO. And hopefully I'm going to be adding to that list over time.

We have launched an initiative which we call Project Public Trust. The thrust of this initiative is to ask hospitals to voluntarily share significant information on quality with the public they serve. We'll begin small with 10 measures selected from the set of measures that are included in the seventh scope of work around heart attack, heart failure, and pneumonia, and expand on that by adding to it measures of patient experience of care, because getting that patient-centeredness we think will be extraordinary valuable. Over time we hope to expand this measure set to be much more robust.

But we struggle with some of the same issues that were reflected in the discussion you just had about quality. That is the fact that we don't currently pay for some of the most important issues in quality and we don't know how to measure some of those important coordination of care issues.

We'll continue to struggle with that as we try to find ways to make public information on hospital quality and those key aspects of it. But we hope that we can coordinate our efforts with yours as we move forward.

Thank you for the time.

MR. HACKBARTH: We will adjourn and reconvene at 2:00.

[Whereupon, at 1:12 p.m., the meeting was recessed, to reconvene at 2:00 p.m., this same day.]

AFTERNOON SESSION [2:01 p.m.]

MR. HACKBARTH: Let's get started with the next section. As you'll recall, the purpose here is to review and comment on CMS' letter on the projected update for physician services.

Kevin?

DR. HAYES: That estimate is based on the statutory formula is an update of a minus 4.2 percent. the Commission is required to review that estimate and provide the results of the review in our June report to the Congress.

I'm going to skip through all the details here and just get right to the key number, which is this minus 4.2 percent. And I'll note the components of it which is an increase in the import prices for physician services of 2 percent.

This figure is comparable to what the Commission recommended in the March 2003 report, which was an update of 2.5 percent. The way CMS reports changes in input prices, they include a productivity adjustment. We break that out separately.

When you combine our estimate of changes, or the estimate that we used on changes in input prices and our

productivity adjustment, we came up with 2.5 percent.

The reason for the difference between their 2 percent and our 2.5 percent was really two reasons. One is their productivity adjustment is 1/10 of a percentage point higher. It's 1.0 percent instead of 0.9 percent. They've used newer information on productivity growth in the national economy.

The other is the difference in their estimate of input prices. Long history here, something that the Commission has dealt with in the past. They choose to use input prices from a retrospective standpoint, changes in input prices up through June of the previous year, before the update actually occurs. So they're using an estimate of the change in input prices through June 30th of 2003, whereas we looked at an estimate for calendar year 2004.

But the big point here is the update adjustment factor of minus 5.9 percent. That's the reason for the negative payment update. And it has to do with a difference between actual spending and the target that is determined by the sustainable growth rate. The difference between the two has widened to the point now where a negative adjustment is required to bring actual spending in line with the target.

There's a small legislative adjustment here you can

see which was required by the Balance Budget Act of 1999, but the total then works out to be his minus 4.2 percent.

MR. HACKBARTH: So the immediate task before us is simply to comment on the estimate and their approached. And the bottom line is that we think this is a reasonable estimate, given the currently available information, but it is subject to change as new data come in, potentially quite large change as I recall from the CMS letter.

DR. HAYES: That's right. They were innovative this time and use stochastic forecasting techniques to identify a possible range for the update and calculated that to be -- they said there was a 95 percent probability that the update would be in a range of minus 5.8 to plus 0.6, I believe. But the biggest probability here is that there will be a negative update.

MR. HACKBARTH: Any questions?

DR. NEWHOUSE: I don't have any questions but I was wondering if we could should make a positive remark about they're providing a range through using this modeling. I think that's a step forward.

MR. HACKBARTH: Other comments or questions?

Okay. Since this isn't a recommendation, I can't

remember if we actually voted on this last year. I think we did, we just included it.

DR. HAYES: So as long as you're comfortable with the draft that we sent you, then that's what will appear in the report.

MR. HACKBARTH: Comfortable with the analysis, not necessarily the result.

And we will add Joe's comment applauding the use of a range.

DR. HAYES: And our next topic.

MR. HACKBARTH: Are you up next, too? You are, indeed.

DR. HAYES: We're here to report on some other work for the June report having to do with growth and variation in the use of physician services. Recall that we discussed this topic of the March Commission meeting and we tried our best to take the results of your discussion and distill that into a draft chapter that we sent to you before the meeting.

This is an ongoing project. It reflects a concern about growth in use of physician services. As you know, the Congress and CMS have pursued a number of initiatives to try and address concerns this area, everything from managed care to

demonstration projects on disease management, even the expenditure target mechanism that we have for physician services is a reflection of those concerns.

The issue is an important one because of its implications for spending. From the standpoint of Medicare beneficiaries, growth and use of physician services results in higher Part B premiums, higher premiums for supplemental insurance coverage, higher out-of-pocket costs. For taxpayers, of course, this results in more competition for general revenues of the treasury. As you know, general revenues are an important source of funding for Medicare Part B generally.

Growth in use of physician services has been volatile at times. Particularly in the 1980s, we saw a range of growth rates from 4 percent to 10 percent and more recently we have seen an increase in spending and use of physician services, some evidence that that started in 2001 and has continued through 2002.

So to provide some focus on this topic, we looked at the data, looked at trends in use of physician services but type of service. We also looked at variation in use of services among geographic areas. And then, drawing upon the research that's been done in this area, we tried to interpret

what we saw in data. And falling out of that was a road map for further work that we can on this topic. And that would appear at the end of the draft chapter for the report.

This is a table that you saw last time. I just wanted to review this briefly. We're looking here at growth in use of different types of physician services. Our measure of service use here is essentially spending where we have adjusted out the effects of the input price adjuster, the geographic practice cost index is for physician services, so that we have a pure measure of use of services.

Looking at that kind of a measure over a period of four years, 1999 through 2002, we've calculated it with constant 2002 dollars. We have data through the first six months of 2002. Full year data are not available yet, but we thought in the interest of making the results as current as possible, we would use data from the first six months of 2002. But that requires a caveat. And what we have here is essentially use of services for the first half of a year. If you were to try to compare these numbers, the service use measures, to say numbers on spending for physician services, you need to realize that this is just for half a year.

But otherwise, what we see here is that overall

growth and use of physician services was, on average for the period of '99 through 2002, 3.6 percent. The other thing I would point out here is the standout category, which is imaging services, which we'll come back to from time to time during this presentation. But that was growing the fastest at 9 percent per year.

This is a map that reflects a further step in analysis of service use here. We're looking at a geographic variation in use of services. And a couple points to make about this, the first is that you'll hear from David Glass and Dan Zabinski in a little about the factors that affect variation in spending. They talk about variations in the cost of providing services as one factor and variation in quantity of care provided.

So this is a way of looking at that second factor, that variation in the quantity of care provided. What we're doing here with physician services is to try and learn more about why that occurs.

To look at this, we have divided the country into -- I shouldn't say we divided the country. But we have looked at variation in use of services among metropolitan statistical areas and the rural areas in states outside of MSAs. To

minimize the effects of random variation in and use of services, we have averaged together the data from the four years that we have been looking at. And because the disease and the burden of disease varies according to such characteristics as age and sex in the beneficiary population, we have aged and sex adjusted these use rates.

For overall service, all services, as you can see shown on this map, we see quite a bit of variation. The highest use areas, I guess it's fair to say, would be parts of the mid-Atlantic, Florida, some parts of the South, and a few areas in states out in the West.

DR. REISCHAUER: This is residence of beneficiaries?

DR. HAYES: Yes, it is.

The next slide is the same kind of thing, but it's for imaging services only, that service that we spoke of a moment ago were we see pretty rapid growth.

This is just use. This is the average for the four years. By once again we see some pretty high -- the patterns are somewhat similar, but we do see some differences, a high use in Alabama or Mississippi, one or the other there, next to do Florida there, and Texas, and parts of the West.

DR. MILLER: So Kevin, the fact that payment rates

are different across the country are not reflected in this data.

DR. HAYES: That is correct.

DR. MILLER: That is essentially controlling for that?

DR. HAYES: That is right.

So then the next step was to try and quantify the amount of this variation and there are a variety of ways to do that. What we did here was to select the 50 largest metropolitan statistical areas. That was, once again in an effort reduce the effect of any random fluctuation in use of services.

What we're comparing here is the area with the minimum and the maximum service use and calculating a ratio of the two.

I want to point out a couple of things about this table before we get into the details. The first is we discovered, in preparing for the meeting, that there is a bit of a difference between how we have defined say evaluation and management services on this table and on a previous table. For the report, certainly, we will reconcile that difference, but just bear that in mind if you try to compare numbers on this

table with the previous table.

The other thing we did here was to take the procedures category of services and split it up into major and other. When we get to the literature on the subject in a few minutes, you'll see why that's the case. It seems like the research on the topic has made that kind of distinction and we wanted to do that here.

But otherwise, what we see is that the variation in use of services is greatest for two categories, tests and imaging, with ratios of 3.5 to 1 for tests, comparing maximum to minimum and 3.2 for imaging. The ratio of maximum to minimum for major procedures, however, is only 1.5.

So how do we interpret data like this? For that we turn to the literature on the subject. From our prospective, there's two major streams of research that might helps us in this regard. The first is what you might think of as this whole area of geographic variation in use of services. John Wennberg at Dartmouth has done a lot of work in this area. I'm sure you're familiar with that. He puts out a Dartmouth atlas on variation in use of services.

Most recent work was by Elliott Fisher and his colleagues. He had a couple of articles that appeared in the

February issue of the Annals of Internal Medicine, received a lot of press at the time when they came out. We'll talk about his results in just a second.

Let me first touch upon the other major area of research in this area, and that has to do with what's been called technological change. One of our Commissioners, Joe Newhouse, has done a lot of work in this area. The focus here tends to be on technological change that is specific to particular conditions. In the case of Medicare beneficiaries, a couple of the conditions that have been looked at are cardiovascular disease and cataracts.

Two types of technological change have been identified. The first has been called treatment substitution. Here we're talking about substitution of one service for another. Often it ends up being more technologically intensive services for less intensive ones. The other type of technological change that's been identified is treatment expansion. Here we see use of services by more and different types of patients.

I think it's hard to capture all of what's been done in this area in one or two sentences, but I think the upshot of it has been in a lot of cases there has been, as a result of

technological change, some increase in spending for treatment of various conditions, but at the same time we also see some evidence of better outcomes.

So it becomes a question of making that trade-off of spending more but also getting better health and better care for patients.

Coming back to the work that Fisher did, it's a pretty sophisticated study. I wanted to devote a slide to it here just to try and explain what was done here. They worked with four different cohorts of Medicare beneficiaries: those who experienced heart attack, colorectal cancer, hip fracture, and then one general cohort representative of the general beneficiary population.

Briefly, what they found was much variation in use of services among geographic areas. The variation was publicly in a category of services that they called more discretionary services, or services that are sensitive to the supply of resources in the area. These services, the categories of them are -- thinking about the earlier table that we looked at, they would be in the category of visits, imaging, tests, and minor procedures. Much less variation with respect to major procedures which was a finding that we saw in the data.

The other major step that they took with this work was to then couple what they found with variation in use of services with some measures of results of quality of care, access to care, and to look at these issues. They had data on improvements in functional status, mortality rates, satisfaction with care, and use of recommended preventive services.

Their overall conclusion with respect to quality and access was that often times it was no better in a high service use areas, and in some cases worse.

So when we put all of this together, this research on geographic variation in use of services, what's been done on the subject of technological change, there are different ways to interpret the results that we see in the data. On the one hand it is possible that there is beneficial technological change going on. We would certainly hope that that is the case, and it is leading to better patient outcomes.

On the other hand, there are these questions about whether all of the services that are being provided are necessary, and that's primarily what we see from the work that the geographic variation group has done.

Where does this lead us? What do we do next? For

that, we laid out a road map here, which is summarized briefly here. Clearly we're not in a position to try and undertake the kind of work that has been done on geographic variation and technological change. Elliott Fisher was kind enough to give us a briefing in the office on his work. And he mentioned in passing that it took him eight years to do this. We certainly don't have the resources to do something like that.

But what we would propose to do is a more targeted approach where we would take the claims data, construct episodes of care, and look at some specific policy-relevant issues. Things like physician self-referral, whether or not use of services is consistent with clinical guidelines that have been established.

Then, depending upon what we find, we would hope that that would put us on a path toward making recommendations for the Congress as appropriate.

That's all I have to say.

DR. NEWHOUSE: Kevin, I thought there was actually some muddying in this chapter of two separate issues that I would like to see more crisply made because I think they have different policy implications for us.

The first is what do we make of the big variation in the cross-section that is at a point in time that I know Jack Wennberg has been hammering away at for four decades or so? And which Fisher is really the latest manifestation.

And it also actually bears on our work later that links spending per state with Jenks ordinal measures of quality per state. It's in that tradition, as well, that cross-section.

What I think that establishes fairly well is that areas that with more services don't -- at least as best we can measure things, which may not be very well -- don't get a lot for it. I'm reasonably comfortable with that conclusion but the issue is then what does that imply for us?

I would say -- I see self-referral and clinical guidelines up here. But I would say in general there is relatively few tools to deal with that. In fact, in principal, in the idealized world of managed care, that was what managed care was supposed to do. And that brought us a backlash trying to deal with that.

Now one can say well, managed care didn't really do that, they just beat up on provider's fees. But still and all, there were certainly tones in the backlash about patients were

grumpy about their procedures not being approved.

So I think the issue there is granted there is this variation. I would have said it's pretty well known. And the issue is what to do. Now that's one set of issues.

But the other set of issues is a quite different set of issues around the spending increase over time. In this chapter, you've got table one actually goes to the growth rate. And then the issue is what does that buy us?

Well, you can't infer from the fact that variation at a point in time doesn't buy much. That spending more over time doesn't buy much, because as you say, the increased spending may be going for new things which may be very worthwhile. And while preserving all the cross-section variation, everybody kind of floats up as the new stuff comes along.

Where that comes back to us is the whole general issues of the update. It certainly comes directly into the discussion over the physician update, but all other updates, really. How much should the pot increase to accommodate this?

One could, in theory, try to bridge them by saying well, maybe the excess will get squeezed out if you hold down the update. But I think we've had enough experience to say that that really doesn't -- the world doesn't work that way.

So I just thought, when we're dealing with growth rates we need to focus on what have we bought for the growth? For that purpose, Fisher and the Dartmouth work doesn't help us. Or at least none of it that I've seen helps us. The Dartmouth does set up another issue, which is what do we do about the cross-section variation? But that's not really the update factor discussion.

So I'd just like those two things better distinguished than we have, both in this chapter and in David's chapter.

DR. HAYES: Would you say that it's okay to include them, to include both of them, but to just make the sharper distinction between the two?

DR. NEWHOUSE: Yes, because I think they go to quite different decisions that we have to make. And as I say, the issue with the cross-section would seem to be what do you do about it? It's there. The results, the implications are probably -- there's a lot of reason to think that, as I say, more spending doesn't buy much or even buys less if you believe the quality slide that we have on order -- that state 51 spends the most and has the lowest quality.

So then the issue is to go to what to do about it. I

don't think self-referral is going to do very much about that variation. That's not to not say we shouldn't necessarily do something there. But as Bob said, the way the DNA of the traditional Medicare program setup makes it almost impossible to do anything about that.

But you still have to make a judgment about the update. And in terms of the discussion that we just had about the SGR, I would have thought what we really do need to establish is something about the value of the increase. That's much harder to do, at least this way.

MR. DeBUSK: Kevin, in looking at the geographic locations where the annual growth rate is going up and looking specifically at the imaging piece, has the certificate of need states been taken into consideration?

DR. HAYES: They've been taken into consideration in that they are on the map. But as we continue to pursue this issue, that too could be on the list of factors that we take into account, just like self-referral. What you're proposing is what, that we look to see the effect that certificate of need has had on availability and use of imaging services?

MR. DeBUSK: Right now there's an explosion of MRIs across the country in the states that do not have a certificate

of need. So ultimately I would think that that would have a real impact on utilization of services.

DR. HAYES: It could.

DR. REISCHAUER: Joe said a lot of what I was going to talk about, but I was wondering do we have any kind of feel or could we find out whether over a period such as you have analyzed, rapid growth occurs in regions of the contrary where initial levels are low?

DR. NEWHOUSE: The technical problem with that is some of that could just be regression to the mean.

DR. REISCHAUER: Was there a chart in here about that?

DR. NEWHOUSE: in one of those two chapters, I thought a chart like that --

DR. HAYES: It's not in this one.

DR. NEWHOUSE: It's in the Dan and David one.

DR. HAYES: We had such a chart in an earlier version of the chapter, where we tried to look at the relationship between growth and baseline use of services and the contribution to growth that was made, low service use areas versus high service use areas. In a nutshell, what we found was that the high service use areas were, I believe,

contributing more to growth than the low service use areas were, despite the fact that growth was highest in the low service use areas.

DR. REISCHAUER: The other thing I was wondering is whether we have any ability to compare this situation with that which exist in the non-elderly population, whether Alice or Jack or somebody could provide some insight on that. You have some private companies like ExpressScrips which has done analyses of medication use across geographic areas, which are rather interesting for the non-elderly population and whether we have a situation which, because of the payment methodology in Medicare, is worse or is better than what you get in the way of both growth and of variation across regional areas than is the case in the private sector.

DR. HAYES: We're developing a database of private sector claims. As you can imagine, there's some serious risk adjustment-type problems associated with comparing the under-65 population with Medicare. But that's out there as a possibility.

DR. NEWHOUSE: But it's also trying to hold the population you're comparing from year to year constant in the under-65. And that's done for you in Medicare.

DR. REISCHAUER: Aetna's a pretty big outfit.

DR. NEWHOUSE: But it's had a big decline in enrollment.

MS. ROSENBLATT: It would be a very hard analysis, just thinking about it on the spot, because of the benefit plan issue, HMO versus PPO issue, because on the HMO if you capitate it you don't have a physician experience. So if we were going to do that, you'd have to think through all that stuff to get something that made sense.

DR. WOLTER: I just have a question about the data and the terminology so I understand this. This service use, when we say that it looks to me like we're talking about the percentage increase in dollars spent on that service from year to hear; is that correct?

DR. HAYES: That's one way to look at it. It's we've stripped out the effect of the price adjustments, the input price adjustments. And the effect of the updates that happen every year.

DR. WOLTER: But specifically my question is if you looked at the number of MRIs done from year-to-year, as opposed to the dollar amount of the number of MRIs done from year-to-year, would the percentage changes be closer to the percentage

changes in E&M codes, since once you apply the RVU and the conversion factor and move the dollars, the actual number of services delivered, that might look a little different? I'm just asking.

DR. HAYES: Yes, it might look different because what our measure captures is both the number of procedures performed and any change in their what's called intensity. We go from what -- I'm out of my area here, but an MRI with contrast media -- without to one with would be a higher cost service. The number of procedures might not change. But in any case, that kind of shift in intensity is also captured in our measure, as well.

DR. WOLTER: It might just be interesting to look at the number of MRIs versus the number of E&M codes. It might be interesting. I don't know.

MR. HACKBARTH: I have Alan Nelson, Carol and David Durenberger.

MS. RAPHAEL: Kevin, I was wondering about our confidence level in terms of your road map to future work. You say that there are clinical guidelines that now tie imaging to CPT codes. I was wondering about whether or not you felt that we could go ahead and really draw some conclusions about the

appropriateness of imaging procedures? Because then you also talk about the fact that there may be underuse of imaging procedures, there may be the wrong imaging procedure used in certain instances.

DR. HAYES: It's hard to do work like this. A lot of the work looking at imaging procedures and other diagnostic procedures has involved examination of medical records, which is something that we cannot do. So we know that going in, that there are some limitations to what we can do. But we feel that there are some pretty well developed guidelines out there that will allow us to at least try do this. If we find out, upon further examination, that it's just not going to work we'll show you what we find and then we'll decide.

But going in anyway, we have some optimism that we can do some of this.

DR. MILLER: Kevin, in some of our discussions with imaging people, the kinds of things that came up were questions of whether there are any standards out there in terms of putting something in your office and whether there are minimum standards being met. And then the notion of how the technology is changing but the payment system isn't necessarily changing with it.

The payment system may say I'm taking a picture of this and this area of the body -- obviously I'm that way out my depth here, too -- but the technology has changed and you just get the whole torso. And yet, you're being billed in Medicare for pieces of it, even though the technology allows you just to move to an entire shot of the area that you're looking for.

And some of the discussions with the imaging people brought a lot of that out. I think some of what we're talking about looking at here is, to the extent that we can look at that even with administrative data and make recommendations about changing how the payment system is paying for it. Is that fair, Kevin?

DR. HAYES: Yes.

MR. DURENBERGER: I'd like to respond to Joe's two questions because they're kind of like critical foundation questions. The first is on the what are we buying and what do we do about it. Every time I see a map like that, and this is quite a few years we've seen maps just like this, I recall the time in 1995 that we sat down with then senior senator from Iowa, who's now the chairman of the Finance Committee with a map just like that. And it took five minutes to convince him about the issue of geographic equity.

Unfortunately we didn't have the second question answered which was -- we knew what to do about it but it wasn't necessarily the right thing to do about it.

So my first response is that the importance of putting this kind of information in a visual sense simply to get people involved in what it is you intend to do about or don't intend to do about present policy is very, very important. It's a matter of stressing the value of this analysis and the deliberate way in which you're going about the analysis itself.

The second one, with regard to the growth rate point, it just strikes me that if you're going to focus on some area on growth rate it ought to be on imaging. I know so little about what is causing it to happen except that I see it in some other work that I do in other parts of the world as well. People asking the question why all of a sudden are we getting so good at seeing so many things and then having to do something about it? And how much of that is appropriate, inappropriate, who's making the decisions? Where are the incentives?

I don't know any of these answers except it strikes me that were we to take -- particularly take the second part of

Joe's question about going into the growth rate part of it, that the whole imaging issue is a critical one for people to better understand. Even though we didn't look up in the upper Midwest like we were an offender, compared to other people, we are. It's going on all over, but at probably different rates of growth.

So the last thing, I guess, is I've always had the impression that with a half dozen huge managed care companies in this country collecting huge amounts of data from huge numbers of people, that they would already have the answer to the question we're asking. Maybe they do. I just don't know.

But it seems like there ought to be a fairly large volume of experience in the private -- on that side of the private sector in these national plans that could help us.

MR. HACKBARTH: Let me pick up on Dave's comment and ask the Commission whether they think that the road map that Kevin has described is the right path for us to be following. We've basically said that the SGR, the current legislative mechanism to control expenditure increases resulting from volume increases is a problematic approach, from our perspective.

Having said that, we could say don't worry about

volume increases at all. Just let it go. Or alternatively, we could say we don't like SGR as the tool for controlling total expenditures. We ought to look for perhaps a sharper tool, a less blunt tool. And I think that's basically the path that Kevin's road map describes.

Once you start down that path, a logical first step, I think, is to try to identify the areas of the rapid increase in volume and he's done that in the case of imaging.

Now there is this school of thought, as he noted at the outset, that well, there's a lot of benefit that comes from that innovation and efforts to target that for control may come at a substantial price in terms of improvements and quality.

I think that's the basic policy crossroads that I'm at in wrestling with it. Do we continue to go down this path? Joe?

DR. NEWHOUSE: I don't think the road map helps us very much with growth because as I -- unless we're going to say in 1995 imaging, X percent of it was appropriate or whatever work we want to use, and in 2002 Y percent was, which is not what I hear being discussed. I hear much more we're going to go into the cross-section variation and look at Minneapolis versus Miami again.

In fact, I would have -- I think imaging by itself is too narrow. I mean, to the degree I understand what's going on here to do -- if we're going to do, for example, minimally invasive surgery -- Nick or somebody should help me -- we need more precise and more images. And maybe that gets the person out of the hospital faster with fewer complications, all which I think is going to be very hard to identify and probably impossible in the cross-section.

The other two points I wanted to make is I thought there was a certain tension between David and Dan's chapter that said gee, health status explains half of the cross-section variation and then -- actually, within that chapter even. But also here. And then the emphasis on the Dartmouth work, that 30 percent of what we do may have no benefit at all. Now both may well be true but there's a kind of mixed message there.

The final point I wanted to make was on self-referral. I'm under no doubt that there's some abuses here, but I think there's a problem in doing the analysis in that if I'm a physician whose case-mix or practice style is going to lead me to do a lot of imaging, I'm more likely to buy a machine and have it in my office than in the oppose case when I may send a few patients across town.

I don't know how to interpret that at the end of the day, or interpret these correlations. Actually, other the studies cited, I think, have that problem.

MR. HACKBARTH: You've expressed reservations about Kevin's road map. We could just stop with the June report and do a descriptive analysis that says here's what we see in terms of where the increases are occurring and stop there.

I, for one, have been pushing Kevin to go further than that and say if we don't like SGR, what do we like? But I don't want to be pushing down that path if you or other commissioners don't think that that's a productive course.

DR. NEWHOUSE: I don't see that analyzing cross-section variation is going to help us with the SGR.

MR. HACKBARTH: I hear that. Where would you look?

DR. NEWHOUSE: I would think -- I mean, I haven't spent a lot of time thinking about it, but you have to go to looking at what was going on in growth rates which means, as I say, going back in time and looking historically at point A and then at point B at some later point in time.

That's a much harder study, obviously, just trying to retrieve old data, codes have often changed, and getting access to charts if you need chart data -- which you probably do to do

this study right. I'm giving you my of off the top of the head reactions here, but I think that's what you have to do.

DR. MILLER: Let me just say this about the road map, because I think there's a couple of different ways to think about it and I think there might be at least some degrees difference in terms of the cross section in what you're saying and what I'm about to say.

I think you could think about this, and I don't think the paper is meant to leave you the impression that it's growth or cross-section. I think we feel like we're trying to look at both of these to figure out what's going on here and where the path will take us, the first point.

The second point, you could organize some of this analysis on the basis of SGR, since we are out there saying it's not working. And then to say nothing else there's little bit of a burden of proof problem where people were saying well, then tell us what will.

My feeling about that is you can actually look at that through growth, which I think is completely fair. But I also think you make the argument that to the extent that you find vast variations in utilization and you can begin to get inside and figure out that it's multiple providers coming

together on a patient and a lot of redundant services, you might say well, I don't know exactly if this is going to change the growth rate, but I can identify a redundancy of services here and, through the payments system, begin to address that and make this argument -- I realize this is a stretch -- that it may help control the growth in volume down the road.

But you could also take that same analysis from the perspective of many of the things that we've been talking about here, about coordinating care, disease management, quality outcomes, look at this redundancy and numbers of providers involved, and make the same sets of arguments and say I just need to construct my payment systems to work in a way that encourages those kinds of outcomes.

Think of a bundled payment for a given diagnosis that looks across it and you don't run the MRI six times, you run it pre- and post-procedure, for example.

I think that's some of the thinking here.

DR. NEWHOUSE: I think that's fine. I just can't make the stretch into the growth implication.

MR. MULLER: I just echo Joe's concerns about how hard it is to do the growth, and I think trying to put together the cross-sectional analysis with the temporal. I think part

of the hypothesis that we have is that as physician practices change, innovation occurs, more drugs, more technology is available, it starts changing not just their patterns but the use of this whole cluster of services. So perhaps there's less hospitalizations, or less nursing home care, more care in the community, all the kind of things we commonly talk about.

So one thing that one can use in that second bullet point there of constructing the episodes of care, trying to get some sense of how care clusters -- and that goes to the point that Mark was just making about how do things perhaps -- do we have any sense of how things interrelate in terms of does everything go together? The old supply arguments, the more you have, the more you use it, which is kind of the early Wennberg stuff, going back 30 years ago. If you have it it will be used.

And therefore, one way that you keep it from being used is to not have it. Which is the way other countries tend to do it.

I would suggest getting to understand more of the episodes of care. I don't know exactly how to construct that. I think it would be helpful in terms of seeing whether if I hypothesize that certain technologies would therefore reduce

other things, is that true? If in fact, you have minimally invasive surgery, you would hypothesize that would at least reduce hospitalization lengths of stay. Does it reduce other things as well or not? More use of images, and so forth, to make sure that the surgery came out well, et cetera, and so on.

So I think trying to construct episodes of care that way on a cross-sectional basis could be helpful in terms of our understanding what the relationship is of the physician utilization to other medical utilization inside the Medicare system, and to see what kind of associations there are. That's one thing one could look at. I, too, despair of doing it over time because of all the data problems and how much the practices do change over time.

Where this takes us then, in terms of what to do about it, aside from go back to bundled payments of smaller or bigger portions, I don't quite know where to take us. That seems to be the conventional wisdom that people have been dealing with for 30 years, you just have to aggregate the payments in some way. As we discussed just before lunch, having some experiments in bundles that are lower than the plan level and some that were above the fee-for-service level strikes me as a good place for the program to keep

experimenting. So I think that discussion, as bout as far as I know where to go on that.

MR. HACKBARTH: The political challenge here is that it appears that the rate of increase in volume and intensity has gone up somewhat. Under the SGR, of course, that produces significant reductions in the update factor. So the problems that we've been concerned about are likely to get worse in the short run as opposed to better. And what I envision happening is that when 2004 rolls around and we express reservations about cutting fees again, the question that will be posed to us well, if not SGR, what do you propose to do about the increasing volume and intensity?

So what I'm trying to do is get us on a path where we'll have at least some organized thoughts in response to that question come next January.

DR. NEWHOUSE: I'm not going to help you with that -- sorry.

MR. HACKBARTH: Let's get some other people involved. Alice and --

DR. NEWHOUSE: I have to leave in about five minutes.

MR. HACKBARTH: Do you want to go ahead then, Joe.

DR. NEWHOUSE: I was just going to make final point

which was there's a chart or a table in a paper by Vic Fuchs in Health Affairs in '99 that shows for several procedures dramatically higher growth rates in the over-85 than in the 65-to-69 for both males and females. Which I interpret as basically people are learning how to do things better and so they're willing to do these things on people that are at a higher risk.

That may be actually one thing to do, is to look at that for a broader range of procedures or update that sort of thing, because then you would say -- that would tend to say you want to pay for some of this stuff, or at least you make a judgment about do you or don't you, but you see more about what's going on than just that Minneapolis has a more conservative practice style than Miami.

MS. ROSENBLATT: When I read this chapter again, my reaction to it was that we should stop it with what we found, the maps and stuff like that. And not present a road map. And I talked myself out of making that comment because I thought I was being a pessimistic actuary.

But after hearing what Joe and Ralph said, they've rekindled my initial reaction to it, which was there's often a lot of analysis that I do looking at Wellpoint, where I'll look

at 10 things and be able to draw conclusions on only one or two of the analyses that I do. You just get caught up in inconsistency of data and you just can't draw conclusions. So I'm a little bit worried about having in the report here's what we're going to do, when it's likely that 50 percent of it may lead to us being unable to draw any conclusions.

MR. HACKBARTH: I think that's well taken and I feel entirely comfortable with taking the road map discussion out of the chapter and just stopping, for now, with the descriptive. Then we can, in subsequent iterations of this, add to the descriptive material by looking at differing rates of increase by age segment. I think that's potentially a very interesting thing.

At some point, though, relatively soon, if we're going to have anything in the way of a policy proposal for next year, we've got to start formulating. And maybe there's nothing we can propose other than bundled payment of various types. But I just want to make sure we don't arrive at that conclusion by default, we've looked down every possible avenue.

DR. REISCHAUER: I guess I'm willing to bet at this point that we're not going to have the silver bullet. I mean, what we're trying to -- we've said we don't like the current

system for moderating growth in physician services expenditures. That's a long way of saying we don't like rationing. But can we come up with another way that is politically viable? I'll be damned if I can think of one.

I look at the analysis in this and ask me where does it point me? It points me to a place that I might be willing to go, but I can't imagine the political system going that direction. And that is what we're looking for is areas where there's high service utilization that involves low value or no value services. If we can identify them, then the appropriate policy response would not be what we have now with the SGR, which is to lower everybody's payments. But to say Minnesota, you'll get the full update, but Miami, Los Angeles, Louisiana, you get minus four.

Given the way our representative democracy is represented, that is not going to go anywhere. So I would stop this, as Alice says, where we are. It's some interesting stuff and maybe somebody can come up some other mechanism but I don't see it.

MR. DURENBERGER: I'm just left uncomfortable with doing nothing, just floating it and saying the pictures are nice, and things like that. If this isn't the right road map,

that's fine. But there's something about the coincidence, as everybody pointed out, of the three chapters, that needs to be addressed here.

On purpose we're looking at the issue of value from three somewhat different directions. One is variation, another one may be the growth in variation. Another one is what's quality and things like that. And we really are doing this on purpose because when you look at that map, there's inequity there.

Whatever explains it, this is a national program and much of the growth is taking place in certain parts of the country and not -- and I'm just speaking from the reality of people that live in my area who do see all the money going someplace else. They can talk anecdotally from their specialty profession about where it ends up.

Now I understand that everything we do has to have a solid foundation under it, but the little deal in the campaign last year in Iowa, which we in part referenced when we were looking at the variation thing, that's another political reality Bob, that we haven't --

DR. REISCHAUER: What is the inequity if another article tells me that the quality of care people were receiving

in your part of the country is better? What's the inequity?

MR. DURENBERGER: The inequity is that these doctors are taking less money and the other third party payers are subsidizing Medicare and Medicaid.

DR. REISCHAUER: But the way our system works usually is if you earn less money doing a task in Minnesota than you do in Florida, people move, resources move there. You don't equalize it by paying more than you have to to get the service you want.

MR. DURENBERGER: It doesn't work that way. It is not going to work that way. It may work that way for people from Alabama going to New York or something like that, but it doesn't happen when you look at communities such as the communities that we represent.

You change, you take some less money, or if some opportunity presents itself, you take your imaging out of the hospital, take your orthopedics out of the hospital, take your hearts out of the hospital, go somewhere else with it, you do that. That simply increases the cost in the system.

It reminds me of the debate we were in in 1989 when we were talking about should we call this resource-based relative values because that's the name it had been given? Or

some of us said we ought to call it value-based relative value system. Except we didn't know how to measure value. Gail Wilensky said she didn't know how to measure value. So we dropped off it.

But the comment element that these three studies seem to have for me is the potential that if we could ever measure value, we would compensate through a big program like Medicare for value. And that seems to be what is common in the quality analysis, the variation analysis, and the one we have before us.

Having said that, I don't have an answer to what Alice recommended, but I just hate to let go of the study.

DR. MILLER: What I would like to come out of this is I have no problem with dropping the road map from the chapter, because I think questions like are going to come up, where we're going to go with SGR is going to come

up, and while I can't articulate it as well as I would like, I truly do see some value or some ability to bridge this research to some of the things we were talking about this morning.

For example, one thing I would say to Bob's comment is you're absolutely correct, you're not going to go in and say

the update for Minnesota is going to be different than the update for Florida. It's never going to happen.

But if a group practice, either on a demonstration basis or not a demonstration, was to say look, I'm looking at these patterns, I'm bearing some of the outcome of this, and we practice our medicine differently, and would come in and say I want to be treated differently -- and by the way, I can get better outcomes and all the rest of it -- there are problems with that approach. How do you define the population? And all those kinds of things?

That's some of the stuff I'd like us to continue to think about, and maybe pull together more than just the couple of chapters we're talking about here. Also think about, down the road, bringing in outcomes as well.

MR. HACKBARTH: We need to move on unless it's really urgent. We're falling still further behind. We won't get out of here until too late.

Thank you, Kevin, wherever you might be.

Joan, I think you're next up, along with Jack. The next item on the agenda is private insurer methods for paying for outpatient drugs. Welcome, Jack.

DR. SOKOLOVSKY: I'll just introduce them and step

aside for a while.

In January, I presented survey results that indicated that the private sector, in general, was paying for physician administered drugs in a manner and at a rate that was really quite similar to the Medicare payment system. But We also found that some payers were beginning to implement new systems, new payment methods for at least some physician administered drugs.

Unfortunately, there was very little work available that had been done describing or cataloging these systems in the research literature. We commissioned a research team from NORC at the University of Chicago and Georgetown University's Health Policy Institute to conduct a series of structured interviews to examine the way physician administered drugs are purchased, distributed, and paid for both under the traditional system and through some of the newly developed methods.

We wanted to learn how these system worked and the advantages and disadvantages of them.

The leaders of that research team -- and boy, they had to work fast, as you can understand here. They're here today to present the results to you.

I'm pleased to introduce Jack Hoadley and Michael

Gluck from Georgetown University, and Dan Gaylin from NORC.

I should mention that this team also completed the study of drugs in the pipeline and their impact on Part B spending that was included in your mailing materials, and I'm sure will be happy to answer any questions on that project, as well. I'm going to turn it over to Jack.

DR. HOADLEY: Thank you, I'm glad to be here.

Basically we're going to talk about several things here and give you a little bit of background just on the context, talk very briefly about the methods that we're using to do our little study. We'll talk about the traditional distribution channels that physicians have been using to date in the distribution of physician administered drugs, a little bit about how payment works in the private sector, and then talk about some of the innovations that have been attempted in the private sector recently and reactions of the different stakeholders to those innovations.

Background I'll be very brief on because Joan has certainly brought you up-to-date in recent meetings on how this works. Obviously we're talking about the physician administered drugs that Medicare typically covers under Part B.

The private sector situation is somewhat parallel and

somewhat different. You often hear the term specialty drugs used, which is not precise equivalent. First of all, there's no precise definition of that term that's used consistently. And it's not precisely equivalent to what Medicare uses. But generally, we're talking about the same set of drugs.

The big difference in the private sector is these tend to be covered under the medical benefit as opposed to their drug benefit, which again is somewhat parallel to Medicare's situation of covering them under Part B as opposed to Medicare's outpatient drug benefit; i.e. no benefit.

And so the claims, therefore, in the private sector are typically not run through a PBM. Cost-sharing would be based on however the medical benefit is structured. And generally, they've had less scrutiny. This is not an area that the private sector has looked at very much.

Very simply, our study was a set of structured interviews, or we could almost say semi-structured interviews, conversations with a number of stakeholders from different parts of the distribution chain. We had a special focus on oncology, since that's the biggest area, probably that's involved with this Medicare Part B drug reimbursement. So we talked to a number of oncologists, insurers, PBM, specialty

pharmacy companies, group purchasing organizations, wholesalers and some consultants who worked with different parts of the field.

Obviously, our numbers were limited by the amount of time we had to do this and there's no sense of a random sample. But we tried to pick representative people from different parts of the industry, different parts of the country, and so forth.

We used a general protocol to set up our questions that we would talk to them about. But mostly it was a relatively open-ended conversation of just trying to understand how things worked.

The traditional acquisition methods that are used in the system, physicians acquire their drugs in a number of different ways for the drugs that they're going to administer in their office. In some cases they may go directly to the manufactures and purchase the drugs directly through a contract with the manufacturer. That's probably not the most common method that's used, but it is used to some degree if they can get a good deal by working directly with the manufacturers. We get a sense that that's more common for some of the ancillary drugs rather than some of the chemotherapy agents.

A major method that physicians use is to work

directly with wholesalers. They may work with large national wholesalers or with local or regional wholesalers that operate in a particular part of the country or in a particular market, or with specialty oncology wholesalers. And there's a number of those that operate that really specialize in the oncology drugs and help to obtain the drugs from the manufactures and move them on to the physicians.

Typically a physician will be under a system where they're getting a regular delivery of drugs. Maybe it's a couple of times a month. Maybe it's as often as a couple of times a week, depending on the volume of their practice.

In some cases they may have an ongoing contract with a wholesaler. In other cases they be looking around and doing almost kind of a spot market and getting different drugs, depending both on their needs and where they can get a good price.

In other cases, physicians use group purchasing organizations to provide them some leverage. This is both in the cases of some large practices who may contract with a GPO to overall take care of purchasing and perhaps some other services, as well, for the practice. It may also be for some small practitioners who really don't have the time or the

resources to work their own deals out with wholesalers or manufacturers.

In these cases, typically the GPO does the negotiating with the manufacturers and the wholesalers, tries to get discounts, and so forth. The GPO tends to arrange the delivery of the drugs but tends not to handle the drugs directly. They'll have a wholesaler who will actually take care of shipping the drugs to the doctor. So the GPO really is playing kind of the middleman operation.

In some cases, the doctors may work directly with a retail pharmacy. And of course, they be doing several of these at once. They may use a retail pharmacy for some special drugs, special circumstances. And this tends to be not so much the CVS, the big chains, but perhaps a pharmacy that's located in the medical building and tends to work directly with the physicians in these situations.

So these may be also used for special orders, for very specific patient situations. Generally, if a pharmacy is providing a drug, those are done under a pharmacy license where the drug may be labeled specifically for an individual patient's use.

So what are some of the issues that come up under the

distribution system as it has traditionally existed? One question we asked was how much do they shop for price? How much is there really a process of going around and trying to get the best prices?

We kind of heard some different stories on this. Some told us that they do only a modest amount of price shopping, that they tend to get settled with a particular GPO or a wholesaler and work on bigger contracts, and may occasionally look for better deals or maybe for certain drugs.

Others told us that there was really a fair amount of shopping going on. So we're not getting a clear signal picture on this particular question. But there clearly are deals out there and there is a market out there. There may be situations where a wholesaler has some drugs that are getting fairly close to their expiration date and a large volume practice may say we'll take those for a discount because we know we can use them while they're still good, before their date has been met. So you get those kinds of deal situations that get created.

In terms of inventory, typically the oncologists are keeping a fair amount of inventory in their offices. We think probably a typical inventory might be a weeks worth of drugs. And maybe for a modest sized practice that's $300,000 to

$500,000 worth of drugs involved. Of course, these are pretty expensive drugs.

They need to have enough drugs in their inventory because when a patient comes in they may look at the patient's blood work and say what I thought we were going to give you isn't right anymore, we've got to switch. And they need to have the drugs in stock to make those changes, or else they're going to have to ask that patient to come back again a couple days later after they get a new delivery.

There are certain drugs not so commonly used where they need to keep them in stock because when they do need them they need them immediately for a particular patient situation.

Then of course, they have to have an inventory system and a lot of them have used these commercial systems like the PCSIS system where you're keying in a particular use of a drug and then there are drawers that are opened up to provide those particular drugs.

A lot of these drugs also have to be kept under refrigeration so the storage considerations are not insubstantial.

The physician may or may not be at risk for -- they're obviously at risk for carrying their inventory, the

carrying costs of maintaining that inventory. Drugs that get spoiled or out of date, they may have prior arrangements with the wholesaler or the manufacturer to be able to return those, either for full price or for a discounted price. Obviously, if there's spoilage in drugs, typically we were told that the physicians are at risk for that. So there are costs to maintaining this inventory.

Quality concerns are, of course, a major part of this as well. I mentioned before, a lot of these drugs require refrigeration. Some of them do have relatively short shelf lives. So they have to really have an active effort to make sure the quality of the drugs are maintained.

We also asked whether some of the other services, patient support services, working with insurers for prior authorization tend to be things that are provided alongside the actual purchase of the drugs. And we were told in most cases that's not the case. The wholesalers typically are not providing those other services. Those are either handled in the doctor's office or they may have a staff person whose job it is full-time to work to get prior authorizations and to do all these other kind of support service. And of course, a large practice will have perhaps specialized staff to do

patient counseling and so forth that goes along with the use of these drugs.

Payment I think you've heard more about from Joan in past meetings, and you're aware that there really are a variety of "prices." And I put that in quotes because some of the prices are not necessarily real prices. You've got things ranging from the actual acquisition price that the physician obtained the drug for. You've got the AWP or the average wholesale price, which as I think you know is sort of a list price that's provided by the manufacturers. And even on AWP, we found that because there's at least two major keepers of the list of AWP, sometimes the AWP itself varies substantially between the two keepers of the AWP list. And so even though it's not a real price in the sense of a transaction price, even the listed price tends to vary sometimes.

There's the WAC, the wholesale acquisition price, which is another sort of nominal price that's listed in some of the books. Then there's the Medicare price.

All these prices sort of are out there. As your previous work has shown you, the private insurers do tend to use an AWP-based price, but those levels -- and we didn't specifically go out to survey levels of price because you've

had that already. But we heard prices ranging from AWP plus 10 percent, AWP minus 20 percent. So again, there's a huge variation out there.

A couple of the doctors also reminded us that even though that's the nominal payment price that's established by the payer, that they still have to collect the co-insurance from the patient, so they're not getting that entire amount from the payer. They're still responsible for collecting some of that. And sometimes that's a problem, they don't always find themselves able to collect that. So they may only get 80 percent of the AWP base price.

The spread is the term that we heard a lot, is the difference between the payment price that the payer provides and the acquisition price. We really heard sort of two stories about the spread, and they were very different stories. When it was told by the insurers, the payers, we heard that the spreads were very large, that there's a lot of money sitting there in the gap between what the physicians are able to acquire the drugs for and what they get paid by the insurer.

When the physicians told the story, the gap wasn't so large. In fact, in some cases it was non-existent. We didn't try to resolve the difference between those two stories, but I

do want to emphasize that really it sounds like you're talking about totally different things when you have these conversations on the one hand with the physicians and on the other hand with some of the payers.

There clearly are some substantial differences in some of the administrations costs that that's spread tends to cover, because as you know the physician administration fee is generally viewed as below the actual cost of administering the drug. But how much of that is really appropriate costs and therefore how much spread is left for just excess income is not so clear.

Moving on to talk about what we've heard about innovations in acquisition and payment, we asked all the people we interviewed where they had experience with some of these new approaches, what they'd heard about if they hadn't had direct experience, and then what they thought about them. We grouped these into five areas and I'll go through each of them separately and then come back after that and describe some of the stakeholder reactions to them.

What I would emphasize that while we grouped these in these five areas, they are used in combinations. They're not mutually exclusive categories. They're also generally, we're

told, in a lot of cases being done as pilots. These are still very new. A lot of the people that are trying these are still experimenting and adjusting what they're doing.

The first of these is what we called the prescribed distribution channels. This takes on a number of variations. But basically it's a system where the insurer, in some sense, takes charge of the system. And rather than just being the passive payer of the bills that come in from the physicians, they are now trying to take over the process, get more involved with the negotiation for price. In an extreme case they may arrange for a single vendor, a single GPO or wholesaler, to take charge of all of the purchase of these drugs for the physicians and for the patients that they're responsible for and then really try to manage the use of these drugs more like a PBM would. In some cases, it is a PBM who then takes over.

Otherwise, we were told that the PBMs had not traditionally been involved in this part of the process. But here's a situation where the insurers may bring the PBMs into this set of drugs. In other cases it's a specialty pharmacy company. And as I say, try to manage this benefit.

In other cases, they may have a choice of vendors. It may not be a single designated vendors but several vendors

that are involved. But again, they are taking some charge and trying to negotiate a good price.

It typically is more of a just in time delivery system where in some cases again, the drugs may be obtained with particular patients in mind. So the physician may tell the insurer that we've got these three patients coming for chemotherapy in the first half of this week and we need the appropriate drugs delivered and they're provided.

In other cases it operates more as sort of an inventory replacement system. The physician, either in advance or after the fact, says here's the drugs I used for this insurer's patients and I need to get my inventory replaced to cover the drugs that I used. In some cases the insurer may give the physician a choice between those two approaches. In others, they may try to mandate a particular way that they want to do it.

Typically, they were combining this with some kind of utilization management. Again, that's part of taking charge both of the price side and of the utilization side. And probably also revising the fees that they pay based on the price that they're contracting with, as well as making adjustments to the physician administration.

Another method is what we called patient purchase. In this case, really we've turned the responsibility over to the patient and it operates more like an outpatient drug benefit would operate. This doesn't always involve the patient actually going and obtaining the drugs. In some cases, the patient actually has to go to the pharmacy and then carry that drug with them to the physicians office for the injection. In other cases, there may be an arrangement where it's delivered directly to the physician's offices. But payment now is handled not through the doctor's office but through the patient. So it's more like your typical outpatient drug benefit. The patient is responsible for their copay and the insurer pays directly for the drug and doesn't involve the physician in that part of the process of all.

We think this is probably more common for some of the standard injections like for MS or arthritis than in some of the infused cancer drugs, but there are some that are trying to do it on the cancer side as well.

Another approach is what we called revised payment levels. This is a simpler kind of change where you basically are trying to make some adjustment in your payment, going from AWP minus 5 percent down to AWP minus 15 percent or some other

kind of shift like this. Generally, this is accompanied by a higher physician fee for administration.

In some cases the insurers will come in and say to the doctors we're going to maintain the same spread you've been getting. We're just going to negotiate a better price and we're going to pay less for the drug. But we'll make sure that your markup is maintained. And obviously they do that to try to get more acceptance from the physicians for making a shift. In other cases this is viewed as an opportunity to really reduce that spread and get both a lower price for the drug itself and then reduce some of the spread and how that's handled with and without the physician fee is maybe done in somewhat different ways.

Then the two other approaches we heard about were just sort of straight out utilization management. This is trying to do the same kinds of things that are done in so many other areas, they try to really manage what goes on, review treatment choices, perhaps make a judgment whether the oncologist is maintaining chemotherapy treatment longer than is appropriate or with a different kind of therapy than appropriate. But we think this is probably more commonly used in the non-oncology settings than it is on the oncology

settings, for a variety of reasons.

And then formularies have been very uncommon in this field until recently. Some movement to going for formularies, partly because a lot of drugs in this area are not multiple source drugs so there may not be a possibility of picking a formulary drug. But in some of the ancillary drugs, some of the anemia treatments, or some of the non-cancer situations, formularies are getting to be possible.

Then turning to how the stakeholders are reacting to these, when you look at the perspective of an insurer or PBM or the specialty pharmacies that are coming from the payers side, their big goal here is to save money. They're trying to reduce what they're paying to get both better discounts and better management. And so they're really trying to influence both price savings and influence utilization of the drugs.

But there are some barriers they're facing. One is data and coding issues. Typically these claims have been paid through J-codes which are aggregated potentially across some different forms and strengths of drugs rather than the NBC codes which identifies each individual product, form or strength and manufacturer. So with the J-codes, it's harder to do that kind of management because you don't have the detailed

information that you sometimes need. Plus a lot of drugs, apparently it takes a long time to get J-codes assigned. So there's a lot of billing done under the miscellaneous J-code. And then again, you're getting less information.

Also, of course, the insurers that have tried to implement these systems have had to address physician resistance. There's a lot of push-back from the physicians on these. In some cases it's been quite dramatic. Physicians said we'll stop providing these treatments in the office, we'll move them to the hospital outpatient department and that's going to cost everybody more money but that's the only choice we have. In one case, there was a couple of months period where that happened and then some negotiating was done and a modification of their original system was implemented.

But the insurers do try to do some outreach. They try to work with the physicians. As I mentioned before they may try to maintain the spread so that they're not taking money directly out of the physicians.

They also have to address a number of distribution issues. If you're taking more charge of the system but there's change in orders, as I mentioned, at the time of treatment, do you have a system that makes it hard to do that? Or do you

have enough flexibility to try to maintain that?

From the patient point of view, there may be quality issues. Those can cut in both directions. If there's overutilization of some of the treatments or incorrect treatments, perhaps there's some improved quality if there's more management of this benefit.

On the other hand, as we'll talk about when we talk about the physicians perspective, there's concerns that the physicians raise about the changing distribution channels and implications for whether they're getting good drugs and whether proper storage is being maintained, and so forth.

There's a potential for lower cost for the patient. If the prices are reduced and the patient is paying 20 percent of the cost, obviously the patient is going to benefit from a lower price. If these are shifted to the outpatient drug benefit, potentially there's some savings there, too, depending on how the cost sharing structure is on their outpatient drug benefit side.

There's also convenience issues or inconvenience issues. If the patient has to go to the pharmacy and pick up their injectable drug, and if this is an arthritis patient or an MS patient for whom that extra trip may be a burden, that

can be pretty serious. If sometimes this means the patient has to come back for a present visit to the office because the original treatment got changed and the proper drugs weren't available, again there may be convenience concerns.

From the physician perspective, I think the biggest things we heard about on the negative side were quality concerns and complexity concerns. Physicians told us a lot about their concerns about quality. That there have been some scandals recently with counterfeit drugs or diluted drugs. And what they tell us is that they really are concerned when they're losing control of the system. They don't know their distributors anymore, when the insurers are mandating a particular distributor and they no longer feel they can vouch for the quality.

Some even raised issues about drugs being delivered in pre-mixed forms. They said this is not a good situation for us. We'd like to be the ones mixing the drugs and knowing that they're mixed safety and on a timely basis. Most of the people putting these new systems in tell us that it's very rare to see a situation where things are being sent out in an already mixed form. So that perhaps is not much of a real issue, but it is certainly something we heard raised.

Then the complicity, the multiple distribution channels. If you're working with five insurers in your practice and each one's got a different designated vendor, how are you keeping track of everything? Have you got five separate refrigerators and storage systems? Okay, that's partly dealt with if you have an inventory replacement system. But even then, there's probably more tracking that you're doing than in the past. At least that's what the physicians would tell us. They feel like they're really losing a lot of control over the system.

On the other hand, it may be that at some point physicians will be happy to be out of the drug sale business. They do have carrying cost for the inventory. And perhaps if the drugs are reimbursed directly by the insurers to the wholesalers, this could turn out in some cases to be an advantage. We don't hear this much yet from the physicians, but people are saying that perhaps physicians will see this. And a lot of it is probably going to come down to the adequacy of payment.

Some of the physicians did tell us that if they felt like the current payment was done on the physician administration side, they wouldn't necessarily have a problem

with getting out of being the ones who are handling the direct payment for the drugs, but then that is the big question. How do you make sure there is adequate payment? I know you've talked about the issues around that in the past.

What are the potential for savings? Because these are new pilot projects, for the most part, it's pretty early to know what the savings are. But we did have two of the people that we talked to give us a sense of the potential savings. One told us that they think on the price side they can get savings in the range of 10 to 25 percent of the cost of this category of drugs. One had done a particular study on their system and felt like they got a 14 percent savings on price, so in the range.

They definitely also felt like there were savings to be had on the utilization side, but those are a lot harder to quantify. They know they can get the direct payback for the added marginal costs of doing the prior authorization or other kind of management steps. But what they're getting in terms of an overall savings on utilization they weren't sure of. In fact, we heard different opinions on whether the utilization side savings would be greater than the price side savings. I'd say we heard no consensus on which had the greater potential.

And finally, I just wanted to mention three lessons I think we learned from what we did. One is it's going to be difficult to make changes. There's a lot of factors. This is a very different market than just purchasing a pill that's going to be used for all consumption. There are a lot of complexity, as I've mentioned, with how these drugs are distributed and stored. And anything you do to change it is going to be complex.

But we also heard two other interesting perspectives. One is that it really may be a different story in oncology versus some of the other specialties, where there are physician administered drugs. And the clinical complexity of oncology treatment is a lot of higher than the complexity of some of the treatments for MS and hemophilia and arthritis and some of the other areas where you have physician administered drugs. It may be worth thinking about how to divide up, and think differently or at least think sequentially, about how to handle things in oncology versus other specialties.

Then we also heard a similar distinction made, and obviously it's correlated, between infused drugs and injected drugs, injected, inhaled, and other forms that may get involved on this side of the drugs. But typically the injections tend

to be more straightforward. There's a given quantity and a fairly known thing. Whereas the infused drugs, it's a more complex clinical situation than doing infusion. It's more common in these oncology infusion situations to have a lot of clinical decisions being made at the point of treatment. So all these methods that try to separate how the drugs are obtained and provided may just be more complex in that area.

So that's the last point I want to leave you with, and I'd be happy to take your questions.

MR. HACKBARTH: Thank you, Jack, Mike, Dan.

MS. ROSENBLATT: I just have one question. Thank you, that was very well done.

You brought up something that I mentioned at our last meeting which was the J-code issue versus the NDC issue. Wellpoint has looked at this and I've talked to some of our people.

I'm also hearing that HIPAA, which is standardizing the J-codes, is making that issue more complex than it would have been before because of the difficulty of changing the J-codes. Do you agree with that?

DR. HOADLEY: I can't really speak directly to that. We didn't get very much into the HIPAA issue. I know we looked

at a little bit, as we were writing up our final report, and I know that there are issues around that but I can't speak more specifically to that.

MR. HACKBARTH: Any other questions?

Okay. Thank you very much.

Joan, you'll pick up with the discussion of the payment options.

DR. SOKOLOVSKY: I know this is a very long day and this is the fourth time that I've been speaking to you on this subject. So I'm going to try to go quickly through this and hope that you'll stop me and ask any questions that you have or comments.

This is the overview of the chapter. As you probably saw in the mailing materials, it's been slightly changed from previous drafts but essentially covers the same issues.

Talking about the overview of the sector, here I do have some new information which you may have noticed in your mailing materials. Although in 2001 was the last year for which we have full data, since our last meeting we now have preliminary estimates of Part B drug spending for 2002 from CMS. I want to emphasize that these are preliminary unofficial estimates and subject to change. But nevertheless, they've

estimated that drug spending for last year may equal as high as $8.5 billion, which would be an increase of almost 35 percent over last year.

These are the problems with the current payment system that we've been talking about for a while. Last month I reported that as CMS had agreed, ASCO had submitted a new survey of practice expenses for oncologists. It was analyzed for CMS by the Lewin Group. And Lewin had concerns with the data and CMS had not accepted the survey. Since then, ASCO has appealed that decision and, among other points, they reported methodological problems with the Lewin analysis.

For example, the analysis includes some extreme outliers in the data, one salary of $1 million for an individual employee. And also collapsed under the category of clerical workers, some high salaried administrators, along with other office workers.

No final decision has been made but as of now discussions continue between CMS and ASCO.

This is the framework that I used to analyze the proposed new payment systems. I wanted to know whether the proposed new method would affect the payments Medicare makes for drugs, whether it would affect beneficiary access to needed

medications, whether it would create new administrative costs both for CMS and also for providers, and how the new system might affect the prescription drug market.

It's important to note here that not all changes are bad. In fact, some changes, like reducing costs to the program and for beneficiaries would be the goal of making a change. But I tried to look at each possible system in terms of those categories.

I also wanted to know whether any new payment system was equally effective for all drugs. For example, a system that might work for generic drugs might not be appropriate for single source innovative drugs. Or as Jack reported earlier, it could be that infusible drugs might require a different system than injectable drugs that might be more like a commodity.

The alternatives that I described in the paper come from Congressional testimony and from reports by sources like the GAO, CB0 and OIG. The list is not exhaustive, but it does seem to capture most of the ideas that are out there in the world. In most cases, policymakers described a list of alternatives rather than making a specific recommendation.

Most of the suggested alternatives really consist of

two parts. First, they choose a price measure like AWP to use as a benchmark for the system. We'll pay AWP minus 5 percent, as Medicare does now. So once you have chosen what your benchmark is, then the second part of the system is to decide what you're going to do with the benchmark. If it's AWP, you usually make some reduction. For some of the other benchmarks that I described in the text, for example the federal supply schedule, that's a price that's below what most providers if not all providers could actually acquire the drug for. So you need to add something to make sure that providers can actually purchase the drug.

A number of recommendations have been made to continue using AWP AS a benchmark but reduce Medicare's costs either by changing the way it's calculated, by increasing the discount from AWP, or using CMS's inherent reasonableness authority to pick out some drugs that we pay for it that are very much above market price and reduce those prices.

Any of these methods that would be used AWP would still not correspond to any transaction price and could not be audited.

A second set of recommendation -- and I would say that these are the most common recommendations -- seek to look

for a new benchmark instead of AWP, a benchmark that would be based on an actual transaction cost and therefore could be audited Medicare would pay providers based on that benchmark. Some of these examples would be the average manufacturer price, which is the press that's used for Medicaid reimbursement, the average sales price, and the average acquisition price. These measures represent the weighted average of all final sales charged for a product by -- what a manufacturer in the United States gets for a product after all transactions, all rebates, and all discounts, except for purchases who would be not counted for Medicaid's best price transaction.

In each of these cases, providers would be paid a percentage above the benchmark and most of the alternatives that are out there that use one of these methods, the main place they differ is how much above the benchmark Medicare should pay.

You've heard about a number of the additional alternatives that are vaguely related to competitive bidding from Jack a little earlier. You also heard about the Medicare competitive bidding demonstration this morning. If we attempted to use a system like this for physician administered drugs, there are several additional issues that would have to

be addressed.

For example, who would do the bidding? Would it be wholesalers, GPOs, pharmacies, PBMs? Would the bidders bid for all drugs or for certain therapeutic classes or for certain conditions? Would the bids be national or regional? How many bidders would be accepted? Who would be paid, the suppliers or the physicians as they are now? Until decisions like these are made it's very hard to evaluate how a system like that would work in terms of the potential savings for Medicare.

Some people have suggested that Medicare pay based on actual invoices submitted to Medicare. One can imagine this being a tremendous administrative issue where each claim has to be handled separately.

George Grob from the IG's office, one of his proposed recommendations was to empower a commission to recommend payment updates in the same way that MedPAC recommends updates for other payment systems. But again, there's so little detail here that I really can't even analyze that.

The lesson that I learned from going through this year-long process is essentially every approach has its advantages and disadvantages. We can't get a perfect approach, but pretty much all of them would result in a significant

improvement over the current system.

Also, in any system, it might be appropriate to vary the payment method by drug type because there are differences. For example, generic versus single source drugs.

Thirdly, payments for drug administration and dispensing also need to be addressed and they should be addressed through the proper payment systems.

And that's it.

DR. WAKEFIELD: You probably mentioned this before or I can imagine I would have asked this question before, but I can't remember what the answer was.

Just taking a step back, in the text you mention that local carriers determine the specific drug products that are eligible for reimbursement. And that there are differences in coverage for specific drugs by regional carriers.

To your point about local carriers making decisions, would you remind me of why that's a good thing? Why that decision is being made by a regional carrier, for example, and so you're getting variation in what's covered, so that that variation is impacting what Medicare beneficiaries region by region might have by way of coverage? Can you tell me why it is that way?

DR. SOKOLOVSKY: In some issues it is a medical necessity decision that couldn't be -- they're not determining specific classes of drugs that should be covered. But it's more a case of is this drug appropriate here? Does this relate to this condition? Is it medically necessary?

DR. WAKEFIELD: So that decision could fall out differently, the medical necessity decision could fall out differently in one region of the country, and people in another region could come to a different conclusion about the medical necessity of a drug to be used for a particular health care problem?

DR. SOKOLOVSKY: For a particular person. That's one thing. The other part, which is more of an issue, I would say, is the self-administered issue. What does it mean under the law now to say a drug that is not usually self-administered? There are differences in interpretation there.

MR. HACKBARTH: Other questions or comments?

DR. STOWERS: This is probably a question. It's silly, but when we were talking about growth in variation in physician service and then we had total and then we separated out evaluation and managing, and imaging. I know in the SGR these are in that under physicians services. When we were

talking about variation in physician services before, are we leaving that in? Are these drugs in all of that?

DR. SOKOLOVSKY: No.

DR. STOWERS: So we took it out. It's just in the SGR?

DR. SOKOLOVSKY: Yes.

MR. HACKBARTH: Others? I think that this is --

DR. STOWERS: The most decisive statement of the year.

MR. HACKBARTH: Most are better than the current.

I think this is a really excellent chapter in terms of A, describing the problem; and then B, laying out what the conceptual alternatives are. As you say, each of them has significant advantages and disadvantages.

What do you see as the next steps from here? We basically have framed questions here. That's the good news. The bad news is that once you frame them, somebody might expect you to answer them. And we've not done that yet. So where do we go from here?

DR. SOKOLOVSKY: That's a very good question. There are additional analyses that can be done of these various alternatives but once again -- and I can, for example, the

issue of the spread. If you take a different benchmark what would be the reasonable difference between the benchmark that would ensure the providers could, in fact, afford the drugs? That's an area of research that can be done.

In many of these cases, unless you get really close to specific proposals, it's hard to evaluate them, to put a number on what they do because it varies so much those details really matter.

In terms of additional work that could be done, you know, I'm really not sure. I have been working since September, going in every possible direction, and beyond that I'm not quite sure where to take this.

DR. MILLER: I think we could do two things here.

First of all, Joan has been doing all of this work and probably hasn't been able to lift her head up and ask what next. And in all of our discussions, we felt that there was enough of, at least for the June report, of a public service to lay this out all in one place and make people understand how this works and what the problems are, and at least conceptually talk about. And a lot of our thinking has only gone that far.

You could potentially stop here and say okay, let the issue mature a little bit on the Hill and see if there's more

to say about specific directions they seem to be picking, because at this point it's not clear there's a horse that people seem to be coalescing around. I'm sure I've just mixed a couple of metaphors there. You could do that.

There's a couple of more narrow issues in terms of drugs and drug payment generally that we can look at. We can do some more work on the administrative cost side and start to look over on the physician side, issues of formularies and some of the directions the private sector is going to, again to see if perhaps that helps inform the debate. But beyond that, I'm not sure I've got any great ideas.

DR. SOKOLOVSKY: I thought of something.

DR. MILLER: Excellent. See, I was just supposed to cover Joan while she was thinking of something.

DR. SOKOLOVSKY: One of the issues that is pretty clear now with the changes in the outpatient system is that we now have payment systems in place between dialysis, where we have statutory rate for Epo which is number one everywhere and growing really fast. We pay one rate there. We pay a different rate in the outpatient department. And we pay still a different rate under the Part B system.

I think there's some work to be done in terms of

looking at the differences across payment systems and what that's doing. How is it or is it not driving care?

DR. WOLTER: Just two things. I think one direction, I think it is essential if we could get people in the same ballpark on the administrative costs of giving these drugs. I mean, it's so linked to the cost of the drug issue that that has to happen, I think.

And then secondly, Joan, I was just going to make the point you just did. I went over with our oncology staff just before coming out here how our chemo drug costs are covered under APCs because in our particular killer organizational setting, physicians are employed and it's a provider-based clinic.

It's so incredibly confusing and it's so incredibly different from what happens in the Part B system. I hesitate to raise this because I don't know how one would work through a comparison of the two settings. But there's something very different now going on in those two settings. And yet, the patients are the same. In many cases the settings are even equivalent, in terms of where the chemo is being given.

So that would be other work, I think, that could have value over time.

DR. WOLTER: Just somewhat tangentially related.

I think at least some anecdotal evidence in the private sector side or employment-based sector side is really calling out the specialty pharmacy management, particularly from our PBMs is something that I think we are looking increasingly at.

Having said that, I think -- and this deals more with the general outpatient as supposed to Medicare's payment here -- there's such a fundamental distrust of all parties, in terms of what we are getting, what we are paying for, what the margins are and what's the most of cost-effective way of doing it, that I worry about that.

Certainly, the second thing, I think, within the employment-based purchasing is really moving much more rapidly to a much more prescribed narrow formulary, perhaps even customized.

Those are sort of two things from the employment-based side.

One question that we might frame, and it might be a little early if Congress is not even picking, as Mark said, which horses in terms of changing the current system . And I think I've mentioned this before. But I asked many of our

benefit managers what kinds of benefit designs and how do we pay for what are going to be increasingly therapeutic agents that, in fact, are going to be customized or tailored genetically for individuals? And how do we deal with that? I get a Coast Guard salute from everybody on that?

I don't know whether we want to raise a question that I think we're going to have to be dealing with pretty soon.

MR. HACKBARTH: As if this wasn't complicated enough already, you want to add still another dimension to it.

DR. WOLTER: Again you've heard me say it, my alma mater treated a Pennsylvania state retired employee and it was something like $200,000 a day was the blood supplement costs on a $5.2 million cost and a 35-day stay. And most of it was drug. That really said, and it was a drug supplement, as I recall, it was being manufactured in London or Belgium or something, and shipped over every night.

We are at that point and we had better start framing the question. So maybe just simply -- and all I can do is think through it and, like I said, I asked a lot of my high paid consultants and I get this vacant look that no, they haven't really thought about that. And how do you ration that? How do you deal with the moral and ethical issues?

MR. HACKBARTH: As I understand the current situation, this issue has been around for a while. There is widespread, if not unanimous, agreement that there's some major issues here. The problem is that the solutions are complicated and there are multiple moving parts that need to work together in tandem in order to address the problems.

That situation seems like a difficult one for Congress to generate the solution to because of its complexity and the multiple moving parts. I think ordinarily they would look to their experts in the Medicare program, namely CMS, to propose a solution to this.

What are CMS's immediate plans? I know they've dealt with one very small piece of this by standardizing the calculation of the AWP. And I've seen reference to Tom Scully saying well, something needs to be done. It sounds almost like he wants Congress to act. I'm not sure who's got the lead right now.

DR. SOKOLOVSKY: He's talked about using the single drug price carrier to conduct a market survey to get an AWP that more closely tracks what the average wholesale price is. He talked about not doing it before May in order to give Congress a chance to act. And I believe that CMS would prefer

that Congress act. I suspect May will slip somewhat.

MR. HACKBARTH: The likelihood that they're going to act by May seems small at this point.

Is there enough there in terms of a proposal that that would be the next logical step for us, to evaluate that path? Obviously not now, for June we're just doing this current analysis. But as is always, I like to know where we're going from here, so far as I can.

DR. MILLER: I think I'd really, to be completely honest, I'd really have to think about whether there's enough infrastructure that we could start to say there are specific directions to go in. Because at least a couple of things that Joan is pointing out here is different distributions make change. You might handle different drugs differently. And then, of course, there's the administrative side of things.

I wouldn't want to sit in this setting and say no problem, our next move should be to put together our next best step. I think that this is something we can certainly think about and maybe bring something to the retreat to try and talk through, if that was your question.

MR. HACKBARTH: I don't think that our comparative advantage in this is trying to formulate a proposal, especially

in an area like this. I don't think we have enough face-to-face time with commissioners. It's a very complicated thing. I think our comparative advantage is in doing this sort of analysis, of framing the issue, and then commenting on somebody else's proposed solution.

MR. MULLER: One of our comparative strengths is the analytical capacity. When you think about whether it's the growth curve going up 35 percent or whatever, among the many problems here, both looking at Joan's presentation or the one before, is the big problem, the "paying too much" for drugs, in terms of purchasing function. It's a big problem, the kind of proliferation of the kind of drugs, with all the biotech coming up and Alan's point to that.

So when we're looking at something that's at $6.4 billion and moving to $8.5 billion, and so forth -- and that $6.5 billion was a lot more than the year before -- just starting to put some rough measures on that in terms of what this is costing us. If they're "overpaying" in the purchasing function, if I can classify it that crudely, what is that worth? If we think AWP minus five is higher than it should be, what are the cost savings of going to a better system?

If the question is really one of proliferation of

these drugs and more and more biotech and designer-type drugs, what is the cost of that? How much of the cost acceleration will come from that?

There's also the kind of ethical, moral concern about the administration fee vis-a-vis the payment and how those things overlap, and what it would cost to clean that one up and so forth. So I think perhaps getting some costs estimate in there as to -- I agree, several presentations have convinced me this is an incredibly complicated area at least I don't want much about. But I think to try to get some sense now of what kind of dollars we're talking about around these various issues in some kind of broad way, to the nearest billion almost or the nearest $500 million as to what -- because when you start having something with a curve of 35 percent
you want to start asking yourself what's the big driver of that? I'm assuming -- I may be wrong -- that it's the real proliferation of the kinds of drugs that we're putting in there, but I may be totally wrong on that.

DR. SOKOLOVSKY: In the mailing materials or in the chapter you have a list of the 20 top drugs for Medicare, seven of them just came on the market in 1996 or later. The new drugs clearly are a very important part of what's happening the

now.

MR. HACKBARTH: It sounds like there are going to be proportionally more biologicals, more single source, which will, all other things being equal, tend to maybe accelerate the rate of growth.

We need to leave this for now. Joan, this is really excellent work in terms of framing the issues. Thank you very much.

We are now on to variation in per-beneficiary Medicare expenditures. This is a tough subject that we've talked about multiple times today already, not to mention in previous meetings. So David and Dan, if you'll walk us through it as quickly as possible, I would Ford appreciate it.

MR. GLASS: All right. Since this is mainly updating last month's presentation we can go pretty rapidly. We basically incorporated the commissioners comments into the draft you received and we want to show you today how we've addressed some of those concern, show the results of some new analysis, and get any other ideas you may have for the chapter.

This is just reviewing, again, adjusting makes a difference. This is going from expenditures, which are those gold bars, to the black bars where we've adjusted for input

prices, health status of beneficiaries, and some special payments made to hospitals. As you can see, the distribution comes in quite a bit, variation decreases. So the apparent problem of massive variation across the land is probably a little overstated if you instead make some adjustments for things that you'd want to adjust for.

There are various measures. We can go from under 20 percent of the distribution being within 5 percent of the national average to over 50 percent.

Now one of the questions that came up was, do Part A and Part behave differently? Is one of them driving it, or the other driving it, or what's the story? So here we show -- this is the unadjusted. This is the expenditures. We have Part A and Part B. Again, this is going against -- plotted on the bottom is the percent of national average this represents. You can see, the pictures aren't quite the same, but interestingly enough, the variation is almost identical.

If we then go to the adjusted version of the same data we can see that just like when we had the summation in the first chart, these all move towards the middle again and variation decreases, not surprisingly given the result for the total. So we don't think there's a big story to be told of

Part A driving it or Part B driving it or anything like that.

Now what all these have shown is that there is some variation remaining, and because of that Dan is going to present some work about what some of the remaining variation might be attributed to.

DR. ZABINSKI: One thing we wanted to do was at least get an idea of the extent to which policy may be able to address the variation in expenditures after we made the adjustments for differences in input prices, health status, and special payments to hospitals. We call that adjusted amount the adjusted service use, as indicated in the commissioners' briefing materials.

Now as part of the method to determine the potential effectiveness of policy, we use regression analysis to identify which variables explain variation in adjusted service use. But because health care is delivered in local markets, rather than doing the regressions at the state level, for which we did the variation analysis to this point, we used the unit of analysis that we believe better approximates health care market areas, that being the metropolitan statistical area, or the MSA, for beneficiaries who live in urban areas, and state-wide rural areas for beneficiaries who live outside urban areas.

Our analysis actually consists of two regressions. In the first, we use only demographic data to explain variation. The results from that regression are indicated on this slide, which shows the coefficients and the t-statistics from the regression for each variable, where a t-statistic greater than two indicates the variable is statistically significant at a 5 percent level. All the variables listed on this diagram exceed that threshold of two, so they are statistically significant.

The coefficients on the table tell us how much a one percentage point change in each of the variables listed changes the per capita service use on average. For example, we'll pick out the percent of the 65 and older population that is Hispanic. The coefficient on that variable is about 20. What that means is that a unit increase in a percent of the population that's 65 and older that is Hispanic increases the per capita service use by about $20 on average.

To summarize the table, I would say that the poverty rate for those who are 65 and older, and the percent of the 65 and older population that is Asian both have negative coefficients, indicating that use rates tend to be lower in areas with relatively high values of those variables. Also,

the percent of the non-Medicare population that is uninsured, the percent of the 65 and older population that is African-American, and the percent of the 65 and older who are Hispanic have positive coefficients, indicating that use rates tend to be higher in areas with relatively large values of those variables.

In our second regression we wanted to test the hypothesis that use of health care services is affected by market conditions such as the supply of health care resources, the technological sophistication of those resources, and the structure of the local health insurance market. What we did is we used hospital beds per 1,000 beneficiaries as a measure of supply of resources, the percent of hospital beds that are in intensive care units, or ICUs, as a measure of technological sophistication, and HMO penetration in the area to represent the structure of the local health insurance market.

Now we did have some concerns about using these variables because we're not necessarily certain of the direction of cause and effect. By that I mean, for example, it's not clear whether a positive relationship between the supply of health care resources and the service use indicates whether a greater supply of resources encourages more service

use or whether high service use attracts more resources. Now we've heard a strong argument by Elliott Fisher that strongly suggests that greater resources, such as hospital beds, does encourage more service use. But I'm sure that some respected researchers could effectively argue against that point.

But despite this uncertainty we have over the cause and effect direction, we did include the market-related variables in our regression and results of that regression include, first of all, that the demographic variables listed on the previous slide are still significant, but some have lost magnitude, as expected. Then second of all, of the three variables that we added for this regression, both the supply of hospital beds and the percent of hospital beds in the IC have positive coefficients and are significant at the 5 percent level. The HMO penetration is actually negatively but it's not statistically significant.

Finally, the R-squared, we have an R-square equal to 0.39 indicated at the very bottom there. What that indicates is that the variables in the regression are explaining about 39 percent of the variation in adjusted service use. What I'd like you to remember is that what we are explaining is -- what the 39 percent explains is the variation that remains after we

have already made adjustments that explain 40 percent of the variation in Medicare expenditures.

Now at this point I had a question, and I'm sure most of you have the same question, is what accounts for the variation we have yet to explain? I think one possibility basically is differences in quality of care. At the March meeting, for example, David showed a diagram that shows that areas with relatively high service use tend to have lower quality of care. Perhaps that means that areas with poor quality of care, they have the idea that poor quality of care creates the need for more services. So maybe you have the concept that if you improve quality care in high use areas perhaps the variation in service use might decline.

A second possibility that might explain the variation we have yet to identify could be differences in pattern practice variation, as argued by John Wennberg and his colleagues at Dartmouth. For example, this is something that Kevin Hayes touched on earlier, they have found that large differences in service use that depend on resources and for which medical science is not well developed, largely explains a lot of the dispersion in health care services. They call these supply-sensitive services and they include things like

frequency of physician visits, use of imaging and other diagnostic tests, use of hospitals as a site of care, and then also use of intensive care units as a site of care.

To summarize, I think probably the key takeaway point from this analysis is that there are limited policy options that may be available for addressing the variation in service use. First of all, we have found that demographic variables explain a fair amount of the variation, but there is little probably that policy can do about geographic differences and demographic profiles.

Second of all, if it is true that greater resource supply does result in more use, I'm not sure that policymakers would be willing to significantly reduce the variation in the supply of resources or the technological sophistication of those resources.

Third, although I think it is possible to address the differences in practice patterns as identified by Wennberg and his colleagues, that may requiring overcoming an obstacle of the desire for physicians to maintain their autonomy and how they practice care.

Finally, I think one possibility at least where policy may be able to be effective is to affect the differences

in quality where they could impact the variation in service use.

That's all I have. I'm going to turn it back over to David and he's going to conclude by summarizing the key findings from our work.

MR. GLASS: Thanks, Dan. So again, these conclusions, most of them you've seen before. The first one is about what measure to use. We keep bringing it up because people keep using the wrong measure. So that's our first conclusion, they should quit using the misleading measure.

The second is, much of the variation is caused by difference in the cost of inputs, health status, and provider mix. We said that covered about 40 percent of the variation at the state level. And as Dan just showed, some of the remaining variations associated with demographic differences and differences in health care supply and technology.

As we said last month, higher quality does not seem to follow from higher use. Again, other research seems to be supporting that conclusion.

Equalizing state payments by increasing use. It's going to increase your beneficiary cost sharing in low use states and that would also increase Medigap premiums and all

that sort of thing. Causes of the remaining variation, which they're probably not best addressed at the state level just because there's a lot of variation within states in terms of, among other things, the health care supply, and health care technology, and in fact the demographics and everything else. So if you want to really get to some of those things you probably have to go to some smaller geographic level, more market-oriented level.

Finally, incentives for high-quality providers might decrease state level variation if those providers happen to be in low use states as it seems likely many are.

One important thing about that is, you wouldn't want to do those kind of incentives for high quality at a state level because that would not be targeted well at all. You'd be giving incentives to providers who are high quality and providers who are low quality. If you're going to do that sort of thing you really have to probably do it at a provider or group of provider level.

That's all we've got.

DR. NELSON: This is obviously very interesting and since expenditure is a product of both price and volume, most of our attention has been directed toward volume differences,

geographical volume differences in calculating expenditures there's a lot of confusion about the magnitude of the geographic differences in physician fee schedule payments for similar services. There's confusion among the profession and there's confusion among policymakers, and oftentimes there's this general perception out there that there's a huge difference in physician payments for the same services from one area to another.

Now obviously the GPCIs make a difference and liability costs make a difference, but some of the practice expense formula was still based on historic charges. I don't know how big the magnitude of the differences is from one part of the country to another, and I think that it useful for us to include some information about that, not only to clarify this issue in the minds of a lot of folks but also to see if we can develop any kind of conclusions about a correlation.

MR. GLASS: We can show -- there's two ways of doing it. You can show what the range is of the variation in the various GPCIs. Then you can also compute like for an office visit, here's what a physician gets paid. Do you think that would be better, more useful.

DR. NELSON: I think it would be useful to have both.

I'm not sure how much -- the GPCI difference is relatively small, just single digit percentages above and below.

MR. GLASS: I'm not quite sure. I don't think that's quite right.

DR. NELSON: I might be wrong. I guess that's another reason I'd like to see some numbers.

DR. ZABINSKI: If Kevin Hayes was here I think he could off the cuff probably answer that question. I know on the hospital side, the effect of the hospital wage index is quite substantial. But I'm not sure how large it is on the physician payments.

DR. NELSON: It's the physician payment piece that I'd be interested in.

MR. GLASS: We could illustrate it with a couple of common procedures, or office visits, or something like that, to show how much it costs.

DR. REISCHAUER: Dan, a couple of questions. You mentioned that about 40 percent of the variation across states was explained by desirable or policy-related factors. Did you do the same for the metropolitan areas? Is it 40, 45?

DR. ZABINSKI: It's really similar. Even when I do it at the county level it's right around 40. That surprised me

a little bit, but that's the way it came out. That's all I can say.

DR. REISCHAUER: It's also that 70 percent of the population lives in metropolitan areas so that's the answer.

DR. ZABINSKI: That's true.

DR. REISCHAUER: The supply variable that you used was hospital beds per 1,000 beneficiaries. I guess that surprised me why you would have beneficiaries as opposed to population overall or some weighted construct which was a national average of the under-65 population's use of hospitals versus the over 65, or doctors per population.

DR. ZABINSKI: I'll answer that last part first, because that's one thing we looked into. Basically I looked at doctors per 1,000 beneficiaries. The reason why, there's really colinearity problems between supply of hospitals and beds and supply of doctors, so you get t-statistic problems.

DR. REISCHAUER: I wasn't suggesting using them both, but one presumes that the doctor has something to do with the fact that the person goes to the hospital.

DR. ZABINSKI: I'm a little behind you on using the general population rather than the number of beneficiaries, what your thought is on why that's better.

DR. REISCHAUER: The ratio of elderly -- total population to non-elderly population varies across the country rather significantly, and all the beds might be filled by lots of under 65-year-old people. They might be there for that reason.

DR. ZABINSKI: I don't have any problem doing it that way. It's simple enough.

DR. REISCHAUER: Then a third suggestion, and I'm not sure quite what I'm thinking here but it was inspired by Alan's point. We're explaining the variation after we've taken out the price differences or the geographic adjustments for cost differences. I'm wondering if we're taking that residual as a dependent variable, it might be interesting to put in as an independent variable what this price variation is. In a sense, if it's wrong in some sense, systematically wrong across the country, over or under, you might get --

DR. ZABINSKI: Are you saying like the hospital wage index as an explanatory variable?

DR. REISCHAUER: Yes.

DR. STOWERS: I've got two or three things. On page 4, we talk about input price adjustments and the local differences in providing care. But then, for example, on down

the wage index is used and then one would expect -- we really get into justifying that the wage index is okay, and there's considerable controversy on whether the wage index, urban, rural, whatever -- in fact we're even trying to fix it in stages with the percentages we put towards --

I'm wondering if that's really somewhere we need to go in this chapter. For us to make that assumption here that it's fine.

MR. GLASS: I'm not sure we're making an assumption. I think we're referring to previous work we did that showed it tended to reflect prevailing wage levels.

MR. HACKBARTH: The analysis that Julian has reported on that Kathleen Dalton did, as I understood it, showed that in the aggregate in fact the wage index was doing a pretty good job of adjusting. And some previous analysis that we had done for the rural report in June 2001 of a different type also led us to a similar conclusion.

That is not to say that for every individual hospital the wage index is accurate. There are some individual hospital issues about accuracy and equity. But in the aggregate, all of the research that we've done suggests that it does a pretty good job. Is that a fair --

MR. PETTENGILL: I'll talk a little bit tomorrow about the nature of the error of the wage index. It's basically that either large hospitals or hospitals located in high wage areas tend to be a little bit overcompensated by the wage index, but otherwise it appears to be pretty much okay.

DR. STOWERS: Then my second part was on the poverty rate 65 and older being actually plus 32. How does that relate, as we've talked in earlier reports about the amount of secondary insurance that they're liable to have, and that relating to the amount of services and so forth? It seems like we could go a step further there as a variable and look at those that have secondary insurance being much more likely to use services. I think that's been back through reports of PPRC and --

DR. ZABINSKI: I thought about that as a particular variable. The problem I ran into was I couldn't get it at the MSA level. I could get it at the state level. One thing I could do -- this isn't entirely clean but it might get you in the right direction -- is take the entire state-wide supplemental insurance rate and apply the same rate to all the MSAs within that state or something like that. I could do that.

DR. STOWERS: I just think that's a tremendous factor in here in the amount of services used as far as patient behavior in seeking services.

Then my last part, I think we have to be a little careful, on page 10, of having a negative be that that would increase the amount of copay of those who are not receiving services. I don't mean this in a funny way, but that would be almost like, I don't want to make more money so I'd have to pay more taxes. If we truly are needing the services then they ought to be offered and I think it might not be so bad that there's more copay to pay in that.

MR. GLASS: Except that the quality thing showed that they don't seem to be needing more services. Just because it's a low use state doesn't mean that they're not getting the needed services.

DR. STOWERS: No, but I'm relating back to the poverty thing a little bit. If truly the poverty people are unable to afford the secondary insurance and are therefore -- I don't think that's all black and white is what I'm trying to say. I do think those that can't afford the secondary insurance are less apt to get care and that kind of thing.

MR. HACKBARTH: If the predominant effect were that

in the low use states, they're low use because people aren't getting needed care, then you would expect a different quality relationship than the one we found in fact.

DR. STOWERS: Looking at it in general. But I'm saying hot spots of poverty may be different.

MR. HACKBARTH: So we can note that to the extent that there's underuse driven by less complete insurance coverage that you'd want to increase that, even if it meant that copays went up. But the principal finding here, looking at the aggregate, is in fact the low use states -- at least based on this limited ordinal measure of quality -- do not have worse quality. In fact, they seem to have better quality.

DR. MILLER: This may be apparent, but I'm just going to say it again. The other point we were trying to make in this analysis is to the extent that people are just talking about just raise the rates in my state, we wanted to make sure that people understood, that has a beneficiary implication because any rate increase they're going to bear, depending on the service.

DR. STOWERS: And I totally agree with that.

DR. MILLER: That was really a driving point we were trying to make sure that people didn't lose sight of.

MR. HACKBARTH: I think that's a critical point that sometimes is overlooked in the discussion.

DR. STOWERS: And I think it's a great point, and I wouldn't change that at all. I still believe there's local access problems that may justify some of these lower numbers. And we shouldn't try to explain that away in looking at access to care.

DR. WAKEFIELD: Last week Tom Scully had the pleasure of being out in North Dakota with the co-chairs of the House Rural Health Care Coalition. I happened to be at one of the meetings that he attended and I understand that, of course, the messages were the same at the other meetings that he was at.

And that was to a person basically almost everyone one of them, actually, who were presenting had a copy of that JAMA Jenks article, interestingly enough, that you referenced earlier, Nick. And of course, they had it because I think it is -- state one at the top is North Dakota, or North Dakota is up in the very top two or three.

And so, the folks who were speaking to him said we're out here, a low use state, from their respective of course disadvantaged by their payment rates. And yet we've got high quality, we're doing really well on -- sort of leading the pack

in terms of at least this set of quality indicators. And why is that? Why is it that our payments here, but our quality is here, and shouldn't there be some incentives in the system associated -- or rewards in the system associated with the provision of high quality care?

So that was that discussion.

But I guess I'd say because you have it as one of your conclusions, incentives for high quality providers might decrease state level variation, and you also mention best not to use states because that washes out differences and lifts the boast of poor quality providers.

MR. GLASS: It doesn't target it well.

DR. WAKEFIELD: Yes, so it's not targeted adequately enough.

Could you envision stepping away from raising rates, for example, with the adverse impact that that has, and was clearly illustrated in the text; i.e., impact on the beneficiary out-of-pocket payments, and so on. And have you thought at all about how else might one incent those providers, either rewarding them or incent providers on quality? That might be different from just lifting rates, bonuses --

MR. GLASS: That was this morning's discussion, I

think, and I do not want to rehash that, that's for sure.

DR. WAKEFIELD: I guess I'm bring it back here, because you put it --

MR. GLASS: That is the connection, though, is that that's why we think a good way of doing it is somehow -- as was discussed this morning. But how exactly --

MR. HACKBARTH: So basically the reference here is to as the reader reads carefully every chapter of our report, they will be clear.

DR. WAKEFIELD: It will hold this together.

MR. HACKBARTH: The links between our different analyses.

DR. WAKEFIELD: All I was saying here is on this one, is there anything else that you can think of that would address this issue, since you've raised it as a conclusion in this particular chapter, that would address this issue of incenting quality. Based on the work you did in this chapter.

MR. GLASS: No, because as we say, we think it should be targeted to the high quality providers or provider groups or whatever you want, but probably not a state or something like that. So I guess we're just trying to make the link to the other discussion of incentives.

DR. REISCHAUER: I want to try again what I tried with David and failed miserably earlier. We're paying a certain price in North Dakota and getting high quality. And if you're in North Dakota, you say I should be rewarded for that. But really the way markets work we should say great, this is efficient. And what we should say is in those areas where we're getting low quality, we shouldn't pay as much.

DR. WAKEFIELD: I understand that. I think the flip side of that is folks are sitting out there with the payments that they're getting. They see what the outpatient outcomes are, at least according to one recent study. And it's hard for them to reconcile those differences. I agree the you, Bob. I mean, absolutely I agree with you.

So you've got all these other folks out there --

MR. DURENBERGER: Don't give in so easily.

DR. WAKEFIELD: But Dave, I've been on here for four years. Over time you get whittled down. You'll experience this two years from now. I'm regressing to the mean, exactly.

I understand your point, Bob, but for folks out there, it's really hard to accept that. That's the point that I'm making.

And what, if anything, should we be thinking about in

terms of linking quality and performance? That's the other point.

DR. REISCHAUER: It was suggested this morning what we should be thinking about is an update where those people who are providing good quality get the full update. And those who aren't get a percentage point below.

DR. WAKEFIELD: I was trying to see if I could get anything like that out of the staff, but I wasn't able to.

DR. WOLTER: Just quickly, I'm still not quite as comfortable on the input price issue as everybody else is. I think there's wage index, there's base rate, there's physician geographic adjusters. And I think that there still may be some issues there that need more attention. I don't think it's an obvious conclusion to me that everything is all set just the way that it should be. So I think that to the extent that that is part of the geographic variation, it might still use some more work.

A couple of other interesting things. It's interesting that the percentage of uninsured rate drives up Medicare costs. That would be an interesting thing for further exploration. I don't know how we would sort it out. Are these people in their late 50s and early 60s who, when they hit the

Medicare program become high users? Is it just serendipitous? Is it related to the relationships between public payment and private payment?

So that if you're less well paid in Medicare and Medicaid, there's more cost shifting into the private sector and the uninsured rates go high. I don't know what it might be, but it might be worth sorting out.

And then it's interesting when we look at the physician services and we look at imaging tests and other sources -- and this is just rough. But in some areas those three areas, imaging, tests and other services, have two times the average use -- two times the average, not two times the minimum. And if we were to then apply the same analysis to hospital services, which I'm sure we've done, where are those areas where the hospital utilization and spending is also at levels like that. And then match that up with this whole issue of where the higher input prices are. It might be interesting to see if there's any correlation there.

But I think that there's some variation based on utilization it would appear from other work, and it's hard for me to reconcile that with the conclusion we imply here, that once we adjust a few things out, the variation becomes much

narrower.

MR. GLASS: I guess I'm not sure why it's hard to reconcile that.

DR. WOLTER: If I read the trend or the drift of the argument here is once you adjust for input prices and patient acuity, the variation's within some more reasonable range.

DR. ZABINSKI: It's a lot smaller, but I wouldn't say it's small. I think there's still a lot of variation left.

MR. HACKBARTH: It explains 40 percent, right? The policy factors explain 40 percent of the variations.

DR. WOLTER: My next question is are the patients sicker in Miami? I think those are the questions people are asking in areas where there is a much lower expenditure annually per beneficiary.

DR. ZABINSKI: According to our healthy status adjuster yes, they are sicker on average.

DR. WOLTER: That would be good information to have.

MR. HACKBARTH: Is there a table in the paper that has the illness analyst laid out?

DR. ZABINSKI: We have one where we sort of add each layer, first do the input prices, then input prices plus health status.

MR. GLASS: We don't have a table by state of health status or by -- the number Dan was using was MSA and state-wide rural. We don't have a table like that.

DR. WOLTER: That would just be a little bit at odds with some of the Wennberg and subsequent similar studies, in terms of expenditure in the relationship to quality. That's all I'm saying.

DR. MILLER: I think we're definitely talking past each other. I think what we're saying is that after you adjust for the fact that a person in Miami is more sick, you're still seeing a level of variation that they are saying 60 percent of that continues out there, and then backtrack to Kevin's paper, he was saying that variation continues to be quite wide, even after you've adjusted for health status.

DR. WOLTER: That would be a great couple sentences to put in that way in this report.

DR. MILLER: I wanted to say this about that comment and a couple of others. One thing that we're working on is that we have an overview that cuts across all of the chapters and a way to try and make these connections between is there an incentive that one could put in here? We're going to try and do that in this overview, which is just not together right at

the moment.

MR. HACKBARTH: I really want to do everything we can to avoid misunderstanding on this point. I don't think that our analysis is inconsistent with Wennberg's analysis. I think they are complementary pieces of analysis. Basically Wennberg and colleagues are focusing on that 60 percent of the variation that is not explained by our policy adjustment factors and health status. Those were very important questions.

The fact that they do explain 40 percent in no way diminishes the significance of Wennberg's work. I noted that in the most recent draft you had responded to my request that we move some of that towards the front of the discussion, and I appreciate that. And I'm going to be looking at that some more, because I think it's very easy for people to lose sight of --

MR. GLASS: Most researchers just blow by the stuff we spend a long time on because they're dealing with a different question really.

DR. ZABINSKI: The starting point is different.

MS. ROSENBLATT: Dan, I have two questions on the analysis. The first one is when you adjusted for HMO penetration, and I was surprised to see that you didn't get

statistical significance. Did you use HMO penetration in the total population or just the over-65.

DR. ZABINSKI: That was the total population. I'm probably going to say too much now, but anyway I'll do it. I think what's going on there is -- and this is just speculation, but this is my gut feeling, is that HMO penetration, they're perhaps heavily in the real low use areas and probably in real high use areas. The idea is that they're in low use areas because it matches well with their nature, and perhaps they're in real high use areas where they see an opportunity where they can have some impact on, wriggle room on having their coordinated care have some effect on the amount of care that's used.

It's sort of like there are two things that are canceling each other out. So in the end, the net impact on the HMO looks really small. But that's just speculation.

MS. ROSENBLATT: I'm not sure I agree with the speculation but I am glad you used total HMO because I think that's more appropriate than just HMO in the over-65.

My other question is did you try any of your analyses truncating the claim amount? Because we've run a lot of analyses trying to look at risk adjusters at Wellpoint. What

we found is we get much higher statistical significance, a much higher fit, of any kind of measurement if we truncate it like $25,000 or something like that, in an attempt to take out the random variation.

DR. ZABINSKI: First of all, we can't -- this is basically from information we got from CMS. And it starts as county level data which we aggregated into the MSA level. So we can't really truncate, in that sense, at the claim level. But I don't think truncating like that would have any effect because we are aggregating to the MSA level. And I generally believe that the population size is adequate enough where outliers don't really have much of an adverse effect on your results in this case.

MS. ROSENBLATT: I don't know because our data in California, we've got a lot of data. And I was surprised at how much of an effect it had. But it sounds like you can't do it anyway.

DR. STOWERS: I'm sorry to delay. I just want to address maybe a disparity here that kind of answers Mary's question a little bit.

I think what we have to realize is what we use for quality indicators are mainly preventive health care services

and those kind of things. And that's not what's the big cost driver in these states. It's the high-tech, as we know, and the imaging services and all of that that are the big dollar items. So I think you could have a state that is looking very good on these preventive measures and not have the dollar disparity.

So it makes sense that there's not a direct correlation in a lot of these cases between what we're using as quality indicators and where the costs are. So if they're doing well on preventive may not mean that they have high exposure.

There's kind of a dichotomy in what the high-priced items are that are driving the costs. And what we're using over here is the quality measure.

DR. ZABINSKI: One thing I forgot to say in response to Alice's question on HMO penetration. Other researchers got the same result that I did. For some reason HMO penetration, the statistical significance just doesn't come out, for whatever reason.

MR. HACKBARTH: To pick up on Ray's comment, I think we do need to be care in the quality section, because these are limited measures and we're using this ordinal ranking. So we

want to be careful not to overstate that finding.

Thank you very much. We are five minutes ahead of schedule and down to our last agenda item, which is the impact of the GME resident cap on geriatricians.

Craig Lisk is listed as a presenter here, but his wife is having a baby. And Bob tells me, Dan Zabinski, that congratulations are also in order for Dan's recent new addition.

MS. LOWE: Without Craig, I'm here to talk to you today about resident caps and the training of geriatricians. This report is required by language included in MedPAC's 2001 appropriations. It did not include a due date.

So what I want to talk to you talking, the appropriations language raised several concerns about whether we have an adequate supply of geriatricians, the needs of an aging and growing population of Medicare beneficiaries, and specifically they were interested in the impact of the hospital specific cap on residents and the effect that that had on the supply of geriatricians.

What I'm going to do here today is try and get to what the report requested, examining the effect of the resident caps and looking at whether or how to alter the cap.

What I want to do here right now is walk you through the evidence that we looked at and the conclusions that we came to. And then if you're comfortable with that, with a little bit of polishing, we can forward this on to Congress. If you want to have some more discussion of this, we can bring this back at our next public meeting in September.

First, a little bit about geriatricians. They are experts in aging-related issues. Geriatrics is a subspecialty of family practice, internal medicine, and psychiatry. A one year geriatric fellowship is required for certification in geriatrics, following ones initial residency in one of those three areas. This requirement used to be two years for certification. It was reduced to one year in the '90s and I will return to that point in discussing a little bit more the importance of that later in this report.

Generally training for those who are pursuing careers in academia is two or more years. Recertification in geriatricians is required every 10 years, and they must maintain their certification in their underlying area of family practice, internal medicine or psychiatry.

Just to point out that many medical schools and residency programs offer elective courses and rotations in

geriatrics.

First to give you a sense of since Congress asked us to look at the resident caps, we wanted to give your a sense of what it means to a hospital to have an traditional resident on the direct side. This gives me an opportunity to first point out two places in existing policies that already provide special treatment to geriatricians. When we see this resident weighting factor, although geriatrics is a subspecialty, geriatric residents are counted as one FTE in this weighted factor, instead of .5 as other subspecialties in their first year of training.

Also, when the per resident payment amounts were frozen in the mid-'90s for specialists, geriatrics was exempted from that freeze. So their per resident payment amounts are about 6 percent higher.

So in this example, you've got a first-year geriatric fellow with a per resident payment amount of $70,000. And given that Medicare's share of the total days, the direct GME that that hospital is getting is about $24,000.

Now over on the IME side, since we spent a lot of time earlier this year discussing IME, I'm not going to spend too much time here. But basically, as you know, the higher a

hospital's resident-to-bed ratio, the higher the adjustment to their payments. And in this example of a 400-bed hospital that's training 100 residents, that adjustment to their payments, given their wage index and case-mix index of one and 2.0 respectively, they're getting about $71,000 in additional payments each year. Combined, the direct and indirect medical education payments for that resident is about $95,000 for the hospital. So as you can see, it's not an insignificant amount of money we talk about when you add an additional resident.

Next, the recent changes in Medicare's GME policies. The Balanced Budget Act placed a cap on the number of residents a hospital could train. And that cap is based on 1996 resident accounts.

I do want to mention that when the caps were put in place, that system, although GME pays for dental and podiatry residents, they were not included in the calculation of the cap.

Basically, what was going on there was that there was a strong financial incentive, as you saw from the last example, to continue to increase the number of residents a hospital is training. The caps were imposed to kind of delink that incentive to train more residents with the financial incentive.

Again, I just want to remind you the two situations I pointed out earlier, the special treatment for geriatricians, the exclusion from the freeze in the per resident payment amounts, and the fact that they're not counted as subspecialists for calculation of that direct GME payment amount.

So next, a little bit about what we know about the geriatricians in training. These are the total number of training positions offered and filled, the offered line being the higher of the two, from 1996 to 2002 based on AMA data. What this chart shows is some pretty steady growth in the number of slots up until 2000 and then a decline. The number of positions filled also grows, but it fell in 2000 when the number of residency positions available actually reached an all-time high. Since then that number of positions filled has recovered to about its 1999 levels.

When we break this up by first and second year physicians, the first year being what's required for certifications, you can see -- I'll show you how these numbers reflect changes in the training criteria, and possibly a general decline in interest in primary care. And just to the point out that these numbers are pre- and post-implementation

of the resident cap. What they do kind of show you here is that there have been consistently more positions offered than those that are filled.

Next, we look just at the first-year positions. And what you can see here is steady growth in the number of first year positions. And as you can also see, the fill rate has fallen significantly since 1999, to about 69 percent. Although after a brief dip there in 2005, the number of residents is now at an all-time high in those first-year training positions.

The growth in the new positions comes from basically two sources that I want to point you two. first, from 1999 to 2002, 13 new training programs in family medicine and internal medicine have been added. Seven other additional programs were added in psychiatry. This inevitably will affect the geographic availability of positions.

But perhaps more substantial is the result of hospitals converting second-year training positions to first-year training positions following a decision of the certification board to reduce the requirement to one year for certification. Now this did have the intended effect of increasing the number of positions available, but when I turn over to the second-year training positions, you can see that

they have taken a significant dip in the number of positions available to actually less than 100 now. Of course, interest, as you can see by the number of positions that are being filled, has been relatively flat. But I just want to point out, too, that this second-year and more training positions is what we would consider the pipeline for those pursing careers in academia, the educators of future geriatricians and providers of geriatric education to all medical residents.

Again, we think a lot of this is caused by substitution of second-year positions in first-year positions.

So quickly let me talk about need and availability. As you can see, the estimates on the range of what we need for clinicians is very broad. This really depends on the model that we used to determine what we need for geriatrics, whether or not we are assuming that at the low-end here the assumption is that primary care providers are providing the bulk of the care, versus the other high end of the model which is assuming the geriatricians are far more involved in the actual clinical care. The range for academics in much smaller, as you can see. And again, these are the estimated need for academics for both geriatric residency programs and all medical residents.

So then we turn to what we know about the current

position. We have about 9,000 people who have been certified as geriatricians. As you can see, that's kind of in the middle of some of these ranges of what we need. But depending on what you believe the model of care is, we could be above or below that need.

What we do know is that the number of certified geriatricians is expected to fall in the short run because there's a very low recertification rate. About 50 percent of people are recertifying. So that's going to cause a dip in the number because there's a far larger number of people who would need to recertify than there are people who are entering geriatrics as new folks coming out of training programs.

This could mean that there's not a large economic incentive to recertify, but it also doesn't mean that these people are actually leaving the profession. It may be that they're not recertifying. So we don't want to indicate that these people are dropping out of practice, although some retirements could be the case here since these are folks who have been in the field for 10 years.

DR. NELSON: Just to point out that the recertification rates are comparable to the other subspecialties of internal medicine, but geriatricians don't

have the option of only recertifying in their subspecialty. They have to recertify in internal medicine as well.

Still, the process is relatively new. Recertification has only been going on for three years. And whether that will pick up or not if anybody's guess. But it's sort of a unique situation.

And I think that expressing concern that the possibilities of the numbers of certified may fall doesn't necessarily mean that they will not still be qualified geriatricians. They just won't have recertified.

MS. LOWE: And that is the clarification that I was trying to make, very important, that these people may still well be in practice.

Just generally, when we're talking about the supply of specialists, we want to understand that there's many factors in here, the patients demand for service, the expected payment including the patient mix, interest in subspecialty, training by physicians, and also the geographic availability of residency positions. And now I want to talk a little bit more about how some of that may be more specific to geriatricians.

First, I want to point out that both hospitals and physicians are making choices about who to train and what type

of training to pursue. Pointing out that under the caps that hospitals are free to distribute residency positions as they see fit. And as you see there, there are a lot of -- and that's just a brief look -- there are a lot of factors that influence what decisions they make about residency positions to offer.

When you think about revenue opportunities, if they're thinking in terms of resident mix, it allows them to bring in a higher volume of the patients or a higher case-mix to add to their bottom line, that could be a very strong incentive. The academic priorities, as Alan alluded to, geriatrics is a relatively new field and some of these institutions will may have very established priorities about their residency programs that would influence the allocation of slots.

And then finally, resident interest -- and this is, I think, especially important for those hospitals that are trying to stay at their cap, in that if interest in a geriatric position is low, they may not want to offer a position that may likely go vacant.

Likewise, the influences on physicians choice of specialty, income potential obviously being a large one,

geriatrics is not perceived as a well-paying specialty, given the likely complex and frail patient mix.

Very closely related to that, the perception of the specialty, that they're caring for very complex patients with usually irreversible conditions.

And finally, the influence of faculty role models in recruiting folks into the profession. It's fairly new and fairly small, and so that effect may be somewhat tempered. And then I'm going to come back in a few minutes and talk more about the income potential and the payment issue for geriatricians.

But first, sticking to this issue of the caps, the conclusion that we're coming to based on the vacancies that are here and the other factors that are involved in these selections is that the caps are not the significant factor limiting the supply of geriatricians.

Secondarily, that lifting the caps is inconsistent with where the Commission has been in previous discussions. As you may recall, we have taken position in the past that policies on the number of distribution and mix of providers should be done through targeted programs.

Just as an aside, I wanted to point out that HRSA,

the Health Resources and Services Administration, actually has a geriatric program through their Area Health Education Centers, that supports residents, especially second-year residents, for those training in geriatrics and to the field of academia.

And then secondly, the discussion that we had for our March report, that Medicare is paying more than the empirically justified amount for IME. If we were to lift the caps on geriatrics, what we're essentially doing is upping the amount of money that's running through IME, as well as increasing the direct GME dollars.

The last point here is that looking at caps benefits all geriatric programs equally, regardless of the quality or the practice model that we think is appropriate. You're offering the opportunity to anyone -- and to point out that, as you can see, there's a lot of positions that are vacant and we're not able to quantify the effect of the quality of the program on their ability to recruit residents into those programs. So I wanted to put that out there as one consideration in lifting the caps. It's a very blunt instrument to maybe nudge up the supply just a little bit more.

Now onto the last slide here. When talking about the

factors specific to geriatrics, I alluded all through this presentation about physician payment. Providers cite a lack of coverage of some of the core services that geriatricians seek to offer management, geriatric assessments, those sorts of things. And also that the payment rates, being that they are based on delivery of a service to a typical patient, may undervalue the services that geriatrics provide because of the time necessary to care for their patient population.

Next, I want to underscore the decision of the certification board to reduce the requirement for certification fro two years to one year. What this essentially did was provide an incentive for hospitals to increase the number of first positions available, which it did have its intended effect. But what it did was remove the financing available for those second-year positions, which is kind of the supply line for the academic geriatricians. And that certainly has had a telling effect in the numbers of positions available for second-year training.

DR. MILLER: By changing from a two year to a one year, there was additional Medicare dollars through DME for that second-year of the program. And when they made this change, they essentially walked away from the dollars, which

made them less attractive to the hospitals.

MS. LOWE: That was an excellent clarification. Medicare pays the minimum time necessary for certification. When they reduced it to one year, the minimum followed that.

The last piece here, when we talk about what is it we think is the proper role of geriatricians in the health care delivery system? The first piece is how do we want to train our future physicians? Do we want all of them to have more training in geriatrics? Or do we want to produce more people who are trained geriatricians? Or some combination thereof? And that's obviously not within the scope of this report, but certainly a consideration when thinking about what sort of supply we want to produce.

The second thing is the model of care for the elderly, given the ranges of need that you saw earlier, is it appropriate for -- if you're training more physicians in geriatrics for more of the care to be delivered by primary care physicians? Or do you want to steer more of the frail elderly to people who are specifically trained as geriatricians? And those are important decisions for other bodies in the profession to be considering.

So I will stop there and ask you for your responses

on the paper and suggestions on the conclusions or any other changes.

MR. SMITH: Marian, I infer from what you said, but wonder if we know that the offered/filled graph would look different for other specialties.

MS. LOWE: The fill rate for geriatrics is lower than a lot of other -- most other subspecialties.

MR. SMITH: So the fill rate is lower?

MS. LOWE: Yes.

MR. SMITH: So the conclusions that suggest that this is related, that there's a big supply side piece of this, seem justified by looking at other fill rates?

MS. LOWE: Yes.

DR. MILLER: I know on a procedure side, on the surgery side, they generally have less problem filling slots. But on the GP/IM side, my sense is that they have the same issue. So I just want to clarify that.

DR. REISCHAUER: I was just wondering, based on what we were asked to do, whether we need an explicit recommendation that this isn't a problem. Or just the tone of the chapter is enough.

MS. LOWE: I think what we wanted to do here is

indicate -- the request of the appropriators was tell us how to change the cap. And we certainly don't want to make a recommendation on -- what I think we're saying here is that we don't think the cap should be changed.

I would defer to you and Glenn and the Commission as to whether or not you want to make a recommendation that says do not change the cap, or whether you want to indicate to the Congress that there are a lot of other issues at play here and we think those are the more important ones for you to focus on.

MR. HACKBARTH: That's certainly my feeling. Is there agreement, consensus, that however worthy the goal of increasing the number of geriatricians or clinicians that have access to some training, however important that might be, the issue here is not the caps? The problem is rooted in other things.

There's agreement on that?

That's the central question that we've been asked by the Appropriations Committee. So was the plan to try to include something in the June report or draft a separate letter of response?

MS. LOWE: The plan is to do this separately and forward it as a separate of response.

MR. HACKBARTH: If that's the case, if there's consensus, what I'd suggest we do is have the staff draft an appropriate letter.

DR. REISCHAUER: But do you attach all this material to it? I mean, it strikes me as a very useful piece of analysis that should be out there for the public.

MS. LOWE: I like to think of this basically as the letter not formatted as such yet.

DR. REISCHAUER: Pretty long letter.

MS. LOWE: Whether at the end of the day this --

MR. HACKBARTH: It's a letter report as opposed to one in a red book or in a white binding.

MS. LOWE: Think of it more like a very thin white report, like we've done in the past.

MR. HACKBARTH: There's precedent for that. We have done letter reports in the past. So it will have an appendix with tables and graphs and what not? Is that what you envision?

MS. LOWE: Yes, the materials that you saw in what we attached will be embedded in the text.

MR. HACKBARTH: Okay. All right. Make it so.

We are done for today. So thank you, Marian.

We'll have a brief public comment period.

MS. FISHER: Brief, but hopefully helpful. thank you, Glenn. Karen Fisher with the Association of American Medical Colleges.

Over the years we've heard concerns sometimes from Commissioners about what medical schools are doing to help respond to future physician workforce needs, et cetera. I'm going to point my comments in two areas. One is to what's going on with geriatric education. And two to the issue of Medicare resident limits, in general.

First, on the geriatric side, the good news is that over the past 20 years, the number of departments and units and specialized areas in schools of medicines that have been devoted to gerontology and geriatrics has increased substantially. The problem is there's still a lag. And as you can see, the problem is the number of physicians who are practicing there is still a problem.

One of the other problems that was pointed out in the presentation that bears repeating is the number of faculty who have geriatrics as their designated specialty. In schools of medicine, faculty play a very important role as role models and in career decisionmaking. And when you don't have faculty who

are doing geriatrics, it's hard for them to go and convince people to go into geriatrics training.

On a positive note, in 2000, the AAMC hooked up with the Hartford Foundation and is distributing $4.8 million in grants to 40 medical schools, a not insignificant number of medical schools, to help enhance their gerontology and geriatric curricula. While it's still early in the process, the survey data from graduating seniors indicates that those seniors gradually from what we call those Hartford schools do seem to have a better confidence, a better knowledge about geriatricians and geriatrics, et cetera.

Now whether that will help them make geriatricians as their specialty, we don't know. We hope so. Perhaps as importantly, we hope that as physicians they will pay more attention and have a better understanding in treating older patients. So we think that's some good news that schools of medicines are doing.

I would like to take a moment to talk a little bit about the Medicare resident limits in general. We have a concern about that. As Marian pointed out, they were imposed by the BBA in 1997.

At that time, many people felt that there would be a

physician surplus by the year 2000. Most people agree now that 2000 has come and gone that there was not a significant physician surplus. And many people out there now are saying that there may be a shortage, and an impending shortage coming in physicians.

We haven't gone that far, even though our members have indicated that there are pockets of shortages in certain specialty areas, in certain geographic areas, et cetera, and we believe more research needs to be done in terms of looking at future physician workforce needs.

What we do know is that, we do think the resident limits are having a chilling effect on the ability of programs, the departments and hospitals, to go into new specialties, to expand existing programs, et cetera.

It is a policy that is one of the tightest probably in Medicare. It's very tight with very limited exceptions. The exceptions relate mostly to rural hospitals which, because of their nature, it's not taken advantage of very much. But we think that resident policy is worth looking into.

I'd like to point out, I think we think that the level of the IME adjustment and the resident cap issue is a very distinct issue, particularly as it relates to GME payments

in the resident cap issue. I would urge you, in your report, to not entangle the two issues of what the level of the IME amount should be versus whether there should be a resident cap issue in Medicare.

We believe those payments are for two very different purposes, between the direct and the indirect. And you'd have to go into a lot of detail if you wanted to bring up the IME level and relate it to the resident cap issue. We'd be happy to discuss that but we think that entangling those two issues is difficult.

We also are glad to see you not recommending an expansion to the exemption for geriatrics because we think this needs to be addressed at a broader level. There are a number of legislative proposals on the Hill to provide expansions for the cap for various specialties, and we don't believe that's the best way to go, to look at this specialty by specialty. But we think it needs to be looked at in a more global way.

So we would urge MedPAC to look, as you look at your agenda next year, to look at this issue and to think about having a discussion about the Medicare resident limits. This has essentially been a freeze on Medicare resident counts for the past five years. And at least we can't recall when there

has been a freeze that has existed with no solution in sight. And by its very nature, freezes tend to be assumed to be temporary in nature. We'd like to have a thoughtful body think about what the next step is and modifications to that.

Now, given our past discussions of the Commission's past discussions on payments to teaching hospitals, I make that recommendation with some hesitancy. But I think the issue is of such import that we're going to go ahead and ask this esteemed body to consider looking at this policy and discuss it at a future meeting.

Thank you.

MS. EMER: I'm Susan Emer with the American Geriatrics Society. I just want to make a couple points.

The first is that when the report was requested back in '99, the fill rate was much higher. It was up at 90 percent. That's something that Marian did mention, but I think it bears repeating. At that point, it was on the increase.

The second point is that. as noted, since then the fill rate has decreased. But I think it bears emphasizing that one of the reasons are the ongoing reimbursement disincentives and then the volatility associated with the update and the fact that geriatricians uniquely have a full Medicare patient base.

And then the other issue, again, is the changes in the CAQ and the fact that this mix affects recruiting patterns, and it's mostly a first year recruitment. And we think that's a short-term transient event, which in future years will change and that the fill rate will then go up.

Basically we feel that the reimbursement issue is something that needs more study, as well, and that that's one of the major reasons for the shortage. I think we do think that the shortage issues could have been discussed more and that's something that future report perhaps can evaluate specifically. What are the reasons for the ongoing shortage and lack of interest in the specialty? And what are some things that perhaps can be recommended to change it?

Finally, I think we'd like to point out that perhaps it's premature to make this kind of recommendation, again based on the shortage issue. And also the fact that we see the certification issues changing after the next year or two.

Thank you.

MR. HACKBARTH: Thank you. We will reconvene at 9:00 a.m.

[Whereupon, at 5:13 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, April 25, 2003.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

**Friday, April 25, 2003**
**9:04 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody. Our first topic for this morning is the implications for beneficiaries and policy reform of supplemental insurance market variation. It's a good way to start the day.

DR. BERNSTEIN: Good morning. We'd like to spend a few minutes today reviewing the June chapter on markets that beneficiaries use to supplement Medicare coverage. Briefly, we'd like to do three things. We'd like to talk a minute or two about what the goals of the chapter are, and how the chapter fits into our broader plan for looking at how markets work or don't work for beneficiaries. Next, Scott will go over some of the findings from work we've been doing in the last couple weeks that's been incorporated into this draft of the chapter. And finally, we'd like to use the time available to get your comments, suggestions, et cetera, on the draft chapter. There are no recommendations in this chapter but we do discuss some issues that might lead to the development of recommendations drawing on the additional research and analysis we plan to do this summer and fall.

There are two reasons why we think it's important to understand how markets for supplemental insurance products

work. First, the chapter lays out significant variations in state regulatory policies and some federal policies as well. States can play a large role in Medigap markets and in how different kinds of health organizations that are allowed to bear risk or to contract with organizations that bear risk, do those things, and in the ways that low income beneficiaries are able to supplement Medicare through Medicaid or sometimes through other programs such as prescription drug programs. A better understanding of how law and regulations affect market entry and exit, and how they affect beneficiaries' access to markets could help to identify ways to reduce barriers to, or to encourage participate in Medicare markets.

Second, understanding how market competition works helps us to focus on specific structural factors like demographics and economic structures that affect the choices that beneficiaries have now. This could be important for thinking through how future market-based reforms might actually play out in different areas and for different beneficiary groups.

The revised chapter draft includes some new sections that introduce broad issues that we would like to address in greater detail in the work that we are going to be doing. In

the draft, these sections are currently labeled policy directions. We need your input regarding whether these are the right directions.

One set of design issues revolves around the concept of level playing fields. This gets to questions about what different types of supplements actually offer in the way coverage and benefits, and how beneficiaries can be helped to make informed decisions among alternates. For example, how much standardization of benefits or standardization of the ways in which benefits and coverage are described is desirable or needed for beneficiaries to be able to make useful choices? Or, can beneficiaries make good choices among alternatives if the rules governing market entry, exit, and withdrawal, and from enrolling and disenrolling from plans vary among the product types?

These design issues are tied up with questions about who's responsible for the regulation and oversight of Medicare-related insurance products, how much federal preemption of state law is needed to ensure equity and access to insurance, or in the types of coverage that are offered across states, or for different beneficiary populations? Who will be responsible for oversight, consumer education, consumer protection, quality

oversight for different kinds of plans if the roles of private markets as a source of coverage for beneficiaries expands?

A lot of these issues are extremely complicated and we don't have enough time to get into them now but we do need your thoughts about what we need to do over time.

Scott is going to walk you through some of the additional analysis we've done that can help us focus on some of these issues now.

DR. HARRISON: Last time I showed you some insurance coverage patterns by state. This time we're going to go and look at some different variables but still bring the state back in. While state differences were clearly apparent, we know that many states include multiple markets. One way to look at markets below the state level is to divide the state markets into urban and rural areas. The 2001 current population survey, or the CPS, the data which forms the basis for most of the tables here. Medicare managed care data come from the CMS administrative data, and both these data sets can be split easily into urban and rural components. Unfortunately, above CPS sample sizes are not large enough to evaluate urban-rural differences within each state and therefore we need to group states in order to get adequate sample sizes.

This slide shows that there are differences at the national level between urban and rural insurance patterns. Urban-dwelling beneficiaries are more likely to have employer-sponsored supplemental coverage and be enrolled in Medicare managed care options, and less likely to purchase Medigap than their rural counterparts.

We checked to see if the national level differences between urban and rural insurance patterns break down at the state level. We hypothesized that if insurance markets are influenced by state characteristics, both the urban and rural markets within a state should be affected by state policies. To test this hypothesis we examined states that were high or low in market penetration for different insurance types to see if they were high or low in both the urban and rural areas. To get adequate sample sizes for this analysis we grouped states together that were particularly high or low for the share of a given product, and I showed you those lists last time.

For example, here we grouped those six states -- the six states are Iowa, Kansas, Montana, Nebraska, North Dakota and South Dakota. They were found to have the highest penetration of Medigap coverage so that's the high group. The low group is 10 states, Alaska, California, D.C., Georgia,

Hawaii, Nevada, New Mexico, New York, Vermont, and West Virginia. That's the low group. This table shows that the states that had relatively high Medigap penetration had relatively high Medigap penetration in both the urban areas and in the rural areas. For each other type of Medicare supplemental insurance, Medicaid, employer-sponsored, and Medicare managed care, we found that, as we do here, that the penetration rate for the high groups are at least twice as high as the low groups for both urban rural areas. So these findings strongly suggest that at least some state market characteristics transcend urban-rural differences between states.

Another way to look at some substate markets is to examine insurance coverage at the metropolitan area level. Unfortunately, the CPS sample size only lets us look at a limited number of metropolitan areas. You have a table in the meeting materials that show the variation among the twelve metropolitan areas that had the largest CPS sample sizes. Sometimes those aren't the biggest cities. I think what CPS does is, if you take a lot from one city in a state, you don't take a lot from a second city in a state because you're trying to get state sizes about right.

I wanted to look at different metropolitan areas within the same state and of the 12 with a sample size of the least 200 only one pair of metropolitan areas were within one state. That was Miami and Tampa, Florida. This table compares Miami and Tampa, and they look very different in regard to each type of coverage. A simple explanation for some of the difference is that 21 percent of Miami's senior population lives under the poverty level and in Tampa that rate is only about half that, 11 percent. I think this shows that while state factors are important, local market conditions can vary and need to be kept in mind.

Let me quickly tell you how you to read these tables. You can't apply sophisticated mathematical formulas like addition on them. The columns don't add. CPS asks a question, do you have this, that, or other, and you can have more than one. So the last column there is the any fee-for-service supplemental, combines those three plus another. So if you had at least one of those you'd show up in the last column.

We hypothesized that supplemental insurance coverage varies by age, which may be a simple proxy for health status. We broke the population into three age groups, under 65, which are the disabled, 65 to 76, and over 76. We broke it at 76

instead of 75 because those over 76 are old enough to have prestandard Medigap.

We found that those under 65 were much more likely to receive benefits from Medicaid. Those in the 65 to 76 age group were the most likely to be covered by employer supplemental insurance. And those over 75 were most likely to have Medigap coverage. The disabled were the most likely not to have any fee-for-service style supplemental coverage. Unfortunately, we don't have the managed care information by age so we have to do without them for this. Those in the middle age group were the most likely to have at least one type of fee-for-service supplemental coverage.

We were able to examine some state regulatory policies with the age group data. We grouped the 14 states that mandated, prior to 1988 -- this is 2001 data -- guaranteed issue for Medigap policies for the disabled. We found that overall those states had slightly higher Medigap participation rates among the disabled, but the difference in participation rates between the aged and the disabled did not close any.

When we looked at the state level we found that the guaranteed issue states had both relatively high and relatively low rates of participation among the disabled. However, of the

seven states that had disabled Medigap coverage reach as high as 15 percent penetration, five of those states did have mandates and one other had recently enacted a mandate. The conclusion we draw is that mandated guaranteed issue for the disabled is not sufficient to ensure higher Medigap coverage, but it may be an important factor facilitating access.

We also examined states that required community rating for Medigap to test the hypothesis that the community rating would increase Medigap participation for the oldest group and lower it for those in the younger aged group because of the implied cross-subsidy that you get in community rating. We could not find any relationship for the eight states that required community rating, although as a group the overall Medigap participation was slightly lower in those states than in the nation as a whole.

That's what we've found so far and would welcome your comments.

MR. FEEZOR: A couple of comments. First off, I thought the chapter was done quite well, given a rather complicated regulatory and product diversity subject. A couple of things. I think we probably need to make more explicit in our conclusion that any move to make for an effective public-

private partnership in dealing with post-65 coverages will require an explicit coordination of policy both across state and federal, and between legislative and executive or regulatory. We say that and the difficulty of the analysis that we bring up I think leads to that conclusion but we need to make it, I think, a little more explicit.

Second, I wonder if a couple of paragraphs in terms of the pre-65 retiree population, either in terms of its growth, its predicament as being probably the least sought-after group in the private insurance market, and its implications for Medicare supplemental might not be worth it on that. So I would offer that as something to think about if it could be incorporated at this date without too much trouble. Scott and Jill, I mention the comment, we probably need to be a little clearer on the Taft-Hartley plans, that they have a different regulatory structure than what you laid out in here in terms of complaints.

Then the other thing we probably do need to mention since we have, in some other chapters or some other products have talked about the seniors counseling program which does enjoy some federal funding, we probably need to reference that. I think it's about page nine or 10 where we talk about the

difficulty of getting information and comparison basis.

Then that leads to the final thing that I think the chapter dealt well with but again maybe needs to be made more explicit, and that is that I think there are -- the reforms that happened in the current Medicare Choice mind-set showed two very different constructs or ideas or approaches to what is best for consumers.

One is where you're trying to standardize so that you can -- standardize the benefits so that you in fact can produce value and comparability, and the other which assumes that you want greater latitude and flexibility, and that individuals are enlightened to do that on their own. I don't know that we've ever really quite reconciled those, or whether they would be reconciled, but I think that shows two very different approaches that are probably a decade apart, and to some degree have some of their lineage perhaps to the more traditional indemnity side, the Medicare supp side versus managed care, the newer entities that are out now in terms of the MCOs that offer the latter.

Other than that, I thought it was -- I've got some edits that I'm going to share with the group, but I thought it was a good job.

MS. ROSENBLATT: I agree, I thought it was a good chapter and I think it made the point well, as Allen said, it really made the point well about the complexity of this market, particularly with the first chart in there, that narrative chart.

The comment you made, Scott, about community rating, and this may be beyond the scope of this chapter but I think you just made the point that in the states that require community rating that the penetration of Med supp is actually lower. It's my guess that that's because the overall premium rates, both to the young and old, are higher because of the effect of community rating. Now I don't know if you've got time to look at that, but it might be worth just making a comment that this could be due to the overall effect community rating on the premium.

I want to echo the point Allen just made on standardization. I sort of feel like this is lecture number three from Alice Rosenblatt, but I'm always in favor of innovation in the marketplace and have always believed that the OBRA attempt to standardization, while it may have made explaining benefits harder, it probably prevented companies from coming out with innovative products. I think that Scully

has recently been promoting that. You had some sentences in here that made it sound like there wasn't much going on, and I think we've got a product in California that is getting a lot more enrollment than we thought it was going to get because it's one of those special product kind of things. I can't describe the benefits to you, but if you wanted to pursue it I could give you the name of somebody at Wellpoint to talk to.

Just a minute thing on the narrative chart that I referred to where you're talking -- it's on the first page of it where you're talking about the employer-sponsored plans. One other thing you should add to the last row there is that the employer-sponsored plans have the ability to vary the retiree contributions so that they can impact what their cost is by passing more cost on to the employee or retiree, so that helps them out.

Then the last thing that wasn't mentioned that I always think should be mentioned, particularly looking forward, is FAS 106. As companies have had to recognize this liability on their balance sheets, many companies have scaled back benefits or -- I think it further makes the point that you're trying to make that as we look out there's a whole group of people that don't have -- the percent of the population that

has the employer-provided benefit I think is going to really drop and part of the causative effect is FAS 106.

MR. FEEZOR: On that, Alice, I think there is a difference between access to employer-based retirement coverage and the actual contribution. They're two very different things and certainly the employer contribution is going to be going down rather markedly I think over time. I hope I'm wrong but I suspect not from everything I've seen.

MS. BURKE: The first is really a question and it relates to the points that Allen and Alice have made. How current is the data on retiree coverage?

DR. BERNSTEIN: The CPS data is 2001.

MS. BURKE: Because my sense is, and I think Allen just pointed it out, that there's an increasing difference in access and actual take-up, in part because of the decline in employer coverage in terms of the cost of those benefits that is shifting that I suspect is going to increase. I think some sensitivity to that as has been suggested I think makes a lot of sense because I think we're clearly seeing a move on that side of the market.

The other just passing note to Alice's point about the value of standardization or the ability to compare, that in

fact was at the heart of much of what occurred in OBRA, and prior to OBRA. It came out of, in part, a fear of the failure of the beneficiary to fully access information that allowed them to make a reasonable comparison and really understand, and that there was a great deal -- I don't want to use the word subterfuge, but there was a fair amount of confusion in terms of what in fact they were purchasing.

So I think while I wouldn't disagree with you that there is value in being able to be flexible, I think we ought not lose sight of the problems that led to a lot of the work that was done at the time. Again, not in a way to be paternalistic that people can't make choices, but there really was enormous difficulty at the time in terms of people being able to understand what it is that was being put before them and make reasonable decisions. So in the desire to be flexible and to be responsive to a market environment, I don't want to lost sight of the fact that there was a reason that led us to the kinds of changes that were made, even further back when we did some of the original Baucus stuff. I think there were real issues there that we ought not lose sight of.

DR. REISCHAUER: At the risk of inciting Alice here, I thought this was all very good and comprehensive and I

learned a lot, but we didn't preface it by saying, this is really a second-best, if not third-best, solution to a problem. Supplemental insurance exists because the Medicare benefit package, unlike most employer-sponsored packages, is inadequate. Various entities, employers, states, individual insurance market, have tried to fill this gap. But what we have is a complex, inefficient response --

MS. ROSENBLATT: I agree.

DR. REISCHAUER: Why did I come today?

[Laughter.]

DR. REISCHAUER: The comment on what's happening to the employer-sponsored market really suggests that over time the employer-sponsored component will become more like Medigap, in the sense that the participants will pay a higher fraction and there will be more restraints on it. I just have to take one dig about innovation here. I think, if I remember correctly the minutia in this chapter there was an example which HCFA had turned down somebody's innovative suggestion that the benefit package include pregnancy benefits.

MR. HACKBARTH: It's not worthy of a response.

DR. REISCHAUER: I thought that was innovation.

MR. HACKBARTH: Going back to Bob's first point, I

agree with that. I think that early in the chapter it might be useful again to make that point. As I recall, we labored over some very artful language to that effect in the June 2002 report on assessing the Medicare benefit package. Just lift that and plant it here.

MS. RAPHAEL: The other part I thought was interesting that I'd just like to see highlighted, when you did a comparison of the beneficiary costs under all these different options, I thought that was particularly important. I certainly didn't realize the differences there.

DR. BERNSTEIN: We could put in a separate chart the pulled that out of the big chart if you think that would be a good idea. We've also run that separately by health status and that's also informative so we can put that in if you want.

MS. RAPHAEL: That would be useful.

MR. DURENBERGER: My comment was the same as Bob's. This is a very exciting chapter, this work, and when it's put together with the report, which preceded my coming on board last summer, it is very, very important product coming out MedPAC. But in order to get the attention of people other than the usual readers of MedPAC reports it really needs to get set up the way Bob suggested, and maybe even more frankly as

opposed to artfully, whatever that may mean, and tied back. There is a phrase which says, previous MedPAC reports have documented the importance -- it would be helpful to restate it. Not the whole report, but just restate what it is that MedPAC said in the past and then flow from that the fact that this will examine both the variation in products and the variation in markets, and then aim to go to some specific studies and so forth.

MR. HACKBARTH: When you think of the time and energy and expense that goes into just trying to understand this market, regulate it, and all of the uncertainty about the implications of different forms of regulation, it really is an incredibly inefficient way to provide these benefits to Medicare beneficiaries.

MR. SMITH: I agree with that. I learned a lot from this chapter in each of its iterations and I much appreciate it. I think it would be useful, sort of building on Bob's point, sizing this market. The share of total health care expenditures that is paid for in this market is always a surprise to people. So making the point that not only is it, at best, second-best because of the inadequacy of the benefit package, but it is a big chunk of total health care

expenditures for Medicare beneficiaries.

MR. HACKBARTH: Any other comments, suggestions?

Okay, thank you.

Next up is comparing beneficiaries treated in long-term care hospitals and other settings. Sally?

DR. KAPLAN: Good morning. Commissioners have questioned what value Medicare receives by paying for care in long-term care hospitals or LTCHs. During this presentation you'll see preliminary results from our research on LTCHs designed to answer that question. These results will be included in the June chapter on monitoring post-acute care. We'll talk about next steps at the end of the presentation. I'll also take questions and comments on any part of the chapter including the post-acute care episode database. I know some of you have comments.

In addition to meeting the conditions of participation for acute care hospitals, LTCHs must have an average Medicare length of stay greater than 25 days. On average, Medicare represents 70 percent of these facilities' patients. About 80 percent of Medicare patients are transfers from acute care hospitals. Long-term care hospitals are the least used post-acute care setting. Fewer than 1 percent of

the beneficiaries discharged from the acute care hospital are transferred to LTCHs.

The number of LTCHs has increased from 109 in 1993 to 287 in 2003. In the last year alone, 21 LTCHs opened; nine of them are located in Louisiana. Spending almost quintupled from 1993 to 2001 from about $400 million to $1.9 billion. That's about a 23 percent average annual increase. Further, CMS estimates that Medicare spending will be $2.7 billion by 2008.

This map shows the location of long-term care hospitals. The location of these facilities is very similar to the high use quartiles that you saw yesterday on Kevin's map, the orange and red sections. Corbin Liu and his associates found that they could describe LTCHs by day of certification. They found some trends in locations, size, type of LTCH and ownership. Old LTCHs, shown on this map by the green dots, were certified before October 1983 or before the acute hospital PPS began. They're located mainly in the Northeast, generally are big hospitals with more than 100 beds, and are freestanding. They're predominantly government-owned or nonprofit. Less than half of their cases come from Medicare.

Middle LTCHs, shown by the blue dots on this map, were certified from October 1983 through September 1993. About

half of these LTCHs are located in the South. Most less than 100 beds, most are freestanding, and almost half of them are for-profit facilities. On average, 70 percent of their cases come from Medicare.

New LTCHs, shown on the map by the red dots, were certified after September 1993 and are mainly located in the South. They are generally small with less than 50 beds, and many are located in acute hospitals. Most are for-profits. On average, 80 percent of their cases are paid for by Medicare. Liu and Associates also found that most LTCHs specialize in respiratory care, rehabilitation care, or a combination of the two.

As you saw on the map, LTCHs are distributed unevenly geographically. Because all LTCHS don't have the same amount of beds we looked at beds per 10,000 beneficiaries by state. On this chart, each bar represents one state. Nine states have no LTCHs and are not shown on this chart. Most states have less than 10 beds per 10,000 fee-for-service beneficiaries. Five states have between 12 and 16 beds per 10,000; Colorado, Connecticut, D.C., Nevada and Texas. Three states have more than 30 long-term care hospital beds per 10,000 beneficiaries; Louisiana, Massachusetts and Rhode Island. That geographic

maldistribution of long-term care hospitals has led to questions about how beneficiaries similar to those who use LTCHs are cared for. This led directly to our research questions.

We questioned whether similar patients that do not use LTCHs stayed in the acute care hospital longer, indicating that acute care hospitals substitute for LTCHs. We also questioned whether SNFs substitute for LTCHs. We questioned how Medicare payments compare and how outcomes compare for patients who do and do not use LTCHs. We also questioned what kinds of relationships exist between LTCHs and the acute care hospitals that refer to them.

I'm going to run through the study methods very quickly before I present the results. We selected patients who had one of 11 DRGs that are common in LTCHs. The data we used came from the 2001 MEDPARs for acute hospitals, long-term care hospitals, and SNFs, and claims for home health. We also used cost reports. We used the location of long-term care hospitals in a hospital referral region as defined by the Dartmouth atlas to identify market areas with LTCHs. The remaining hospital referral regions became market areas without LTCHs. We used the acute hospital diagnoses and 3M's APR-DRGs to obtain a

severity of illness score. We also used APR-DRGs to obtain a risk of mortality score. We defined an episode as beginning with an acute hospital stay with one of the 11 DRGs. Episodes ended with death, readmission to an acute hospital or no Medicare Part A services for 61 days.

First I'm going to show you our results from comparing market areas with and without long-term care hospitals. Then I'll show you the results from comparing post-acute care users within markets that have LTCHs.

To show you the difference between markets with and without LTCHs I'm going to show you some slices of a table with demographic characteristics, clinical characteristics, and care use. I'll also show you comparisons by DRG and severity level. As the tables and figures you'll see demonstrate, there are few differences between the two groups. On this slice of the table, the only difference is that there are more whites in market areas without LTCHs.

On this slice of the table --

DR. MILLER: Sally, can I just say one thing really quickly? What we're first trying to do is just run through and see whether there's something systematically different about the market areas. And then within the market areas, to see how

the patients are handled. Which is just a different way to say what Sally is saying.

DR. KAPLAN: On this slice of the table you see two differences; patients in market areas with LTCHs are slightly more likely to use an intensive care unit in the acute care hospital. The other difference relates to using an LTCH.

Now we look at the average length of stay and payment. All the payments you see in this study have been adjusted to remove the effect of the area wage index. The average length of stay for the acute hospital is the same for market areas with and without LTCHs, six days. So is the average length of stay for the entire episode, 21 days. The acute hospital payments differs by 3 percent, and the total payments for the episode differs by less than 5 percent between the two areas.

Now we're still comparing market areas with and without LTCHs. On this slide and the next slide I'm going to show you the distribution of severity levels for four of the 11 DRGs. On this slide are DRG-14, commonly known as stroke, and DRG-127, commonly known as congestive heart failure. As you can see, the distribution across the severity levels and the share that this DRG makes up of the 11 DRGs are identical for

areas with and without long-term care hospitals.

Now we see the two DRGs that are related to ventilator care. As I said, many of the LTCHs specialize in ventilator care, 475, respiratory diagnosis with ventilator support, and 483, tracheotomy with mechanical ventilation. As you can see, there's no difference in the distribution of severity levels or the proportion this DRG makes up of the 11 DRGs. The lack of differences between market areas with and without LTCHs is consistent across all 11 DRGs. Based on what we've seen, there are no systematic differences between market areas with and without long-term care hospitals.

Now we're going to look at the results from comparisons of patients who used and did not use long-term care hospitals within the market areas that have long-term care hospitals. Because we are interested in comparing similar patients, we look at post-acute care users in markets with LTCHs. This chart compares severity levels for all 11 DRGs. As we expected, many of the patients using LTCHs are in severity level four. Patients with lower severity levels make up about 30 percent of the LTC patients in the 11 DRGs.

We questioned whether acute hospitals substitute for long-term care hospitals. When we compare similar patients who

used and did not use LTCHs by DRG and severity level, we find that LTCH users had longer acute hospital lengths of stay. For 37 out of 44 DRG severity level categories, LTCH patients had a slightly longer length of stay. In 35 categories the difference was less than one day. Therefore, acute hospitals don't appear to substitute for long-term care hospitals.

We also questioned whether SNFs substitute for long-term care hospitals. We found that patients who use long-term care hospitals were three to five times less likely to use SNFs. If LTCHs do not substitute for SNFs we'd expect the same proportion of patients to have used SNFs whether they used an LTCH or not. We found that 60 percent to 90 percent of patients with severity level four who didn't use LTCHs, used SNFs. Therefore, SNFs appear to substitute for LTCHs for many patients. However, I want to remind everybody that these are descriptive statistics so therefore they are not definitive. We will be doing multivariate analyses.

We questioned how total payments compared. Pre-PPS total payments are generally higher, were generally higher for patients who used long-term care hospitals. The difference in total payments for lower severity patients is greater, up to 156 percent higher for patients who used LTCHs. For patients

with the highest severity level, total payments were 44 to 90 percent higher for patients who used LTCHs. DRG-483, tracheotomy with ventilation, severity levels three and four are exceptions. Between patients that did and did not use LTCHs, total payments were only 10 percent different for severity level three and 2 percent different for level four. However, these are pre-PPS payments.

We questioned how outcomes compare. We looked at death rates and readmission rates by DRG and severity level. The death rate was higher for patients who used LTCHs. For example, severity level four patients in most DRGs who used LTCHs had a death rate that was 10 to 45 percentage points higher than patients who did not use LTCHs. It is difficult to know what to make of the difference in death rates. It may be an unmeasured indicator of severity of illness. It may indicate that LTCHs provide end-of-life reflect care.

Readmission rates present a mixed picture. At the highest severity level, LTCH patients are less frequently readmitted than post-acute users of the same severity level, from 6 to 37 percent less frequently. At the lowest severity level they are more frequently readmitted, from 7 to 76 percent more often. In the multivariate analysis we will adjust

readmission rates for death.

The maldistribution of LTCHs, SNFs apparent substitution for LTCHs, LTCHs admitting patients with lower severity of illness, that LTCHs are more expensive but have mixed outcomes, means that we need to drill down to be able to say whether the quality of outcomes justify the greater expense of LTCHs.

Now we change the subject a bit to try to answer the question about what kinds of relationships LTCHs have with acute hospitals. We looked at the share of cases LTCHs received from their primary referring acute hospital, which basically is the acute hospital that refers the most cases to the LTCH. We looked at the share of cases LTCHs received. On this chart each dot represents one LTCH. On average, long-term care hospitals located in acute hospitals, the blue line, receive 61 percent of their cases from their primary referrers. Other LTCHs represented by the fuchsia line, on average receive 42 percent of their cases from their primary referrer. There are LTCHs in both groups that receive as far as 10 percent of patients from one hospital and as much as 100 percent of patients from their primary referrer.

Then we examined what the primary referring acute

hospitals look like. This table compares the primary referrers to the nation's hospitals. Primary referrers are much more likely to be urban and more likely to be teaching hospitals. In addition, not shown on the table is that the primary referrers are more likely to have a volume of more than 10,000 cases per year, so they are pretty large hospitals. The Medicare inpatient margin for primary referrers is 28.8 percent. That compares to a Medicare inpatient margin of 10.8 for all acute hospitals.

These are some of the next steps for the research on long-term care hospitals. We want to model total payments under the PPS since that's what LTCHs are operating under now and will continue to operate under. We want to compare Medicare's costs and quality, controlling for other factors; determine other provider types are converting to long-term care hospitals; and examine financial performance for these facilities. We plan to be back in September with those results.

Now I'm happy to take any questions or comments, either on this section of the chapter or the section of the chapter on the post-acute episode database. Nancy is ready to join me if the questions get beyond my capability.

MR. HACKBARTH: Can I just ask a question, Sally, about the inpatient Medicare margin for the primary referrers versus the other acute hospitals? The inpatient Medicare margin is dramatically higher for the primary referrers, yet if you go back a number of charts the acute hospital length of stay is essentially the same in the areas where there are long-term care hospitals. The inpatient Medicare margin difference could well just be a function of the fact that they're teaching hospitals and are they're receiving IME and DSH, as opposed to anything to do with long-term care hospitals; is that true?

DR. KAPLAN: Yes, it could. We actually asked for -- there are two things I want to say about that. First of all, the Medicare inpatient margin for teaching hospitals is 22.9 percent, so this is considerably higher than that. Second of all, we did ask for the margin information taking out the IME above the empirical level and DISH. I don't have that at this point so that I can compare what we found that's represent in the March report. I'm not sure that we've use the same methodology so I need to go back and check that. So I was reluctant to present that information.

MR. DeBUSK: Now with LTCHs in the post-acute arena we've been going to a prospective payment system phased in over

a period of time. This actually started last October for LTCH, right?

DR. KAPLAN: That's right.

MR. DeBUSK: Now, Sally, the phase-in period of time for LTCHs is what?

DR. KAPLAN: It's a five-year phase-in, but they have the option to go to 100 percent PPS immediately.

MR. DeBUSK: So actually, to see where this is going to lead this whole situation, we need some of that data before we can really judge where this is headed, right?

DR. KAPLAN: I think we can model the PPS payments. That's why I want to model the PPS payments. I think that will give us a clearer picture of what the total payments are for these types of patients if we modeled the PPS. CMS estimated that over 50 percent of the LTCHs would pick up the option to go to 100 percent of PPS immediately.

MR. DeBUSK: As I understand, that hasn't happened, right?

DR. KAPLAN: They do that by their fiscal year. So in other words, if your cost reporting year started on January 1st, you had to let CMS know that you were converting to 100 percent PPS right away.

MR. DeBUSK: The reason I bring that up, I think there's two national chains that own better than 50 percent of the total LTCHs in the country and one of them in phased-in and I think the other has not even started yet, so a significant number hasn't hit the chart yet, right?

DR. KAPLAN: I don't know.

DR. REISCHAUER: Just a little bit of education for me. Am I right that the acuity is about the same in the areas with and without, and for these selected DRGs the total episode payment is only 5 percent difference?

DR. KAPLAN: When we look at the areas with and without --

DR. REISCHAUER: I'm trying to reconcile this with how much more it is --

DR. KAPLAN: I think it's because there are so few -- don't forget that less than 1 percent of the patients discharged from an acute care hospital go to a long-term care hospital. It's because there are so few long-term care hospital patients, only 72,000 admissions.

DR. REISCHAUER: But this isn't just -- I thought you were selecting a set of DRGs that were particularly --

DR. KAPLAN: Yes, but even so it's not that many

cases. For example, 483 --

DR. REISCHAUER: Even in areas where there are -- I mean in Louisiana or Texas --

DR. REISCHAUER: I haven't looked at Louisiana separately although it's been suggested that I do that. But, no, I have not looked at states individually. We looked at basically market areas with and market areas without. We didn't look at states. I can do that.

DR. REISCHAUER: It just surprised me. I would have expected to see a much bigger difference and I thought, are we looking for a problem that doesn't exist?

DR. KAPLAN: I think the fact that you have 72,000 cases in 2001 and if you looked at -- you have 1.8 million patients in markets with long-term care hospitals, so that's getting very diffused.

DR. REISCHAUER: By the way, I think this is a tremendous piece of analysis. I really like it.

DR. KAPLAN: Thank you.

MS. BURKE: Sally, can I just follow up on Bob's point, because I'm struggling with the same question. If I turn to page 10 of your charts and the numbers that Bob was referring to, I'm not sure I fully appreciate what those

numbers mean in the total episode cost. Because it seems at odds with the suggestion that there are enormous differences. To Bob's point, I'm trying to figure out, is there a problem or is there not. Are these patients in fact resulting in the same cost for the entirety of the episode involving both the acute and the use of LTCHs as compared to people who use acute and a sub-acute unit, a SNF or something. I'm just struggling to understand where the problem is, if these numbers suggest that to date at least our experience suggests that the costs are the same.

DR. KAPLAN: That's what I was trying to say to Bob. I think it's because you're taking 72,000 patients -- actually less than that because you really are only taking the 11 DRGs out of those 72,000 patients.

MS. BURKE: Right, but they're the most frequent.

DR. KAPLAN: But if you think about the fact -- actually, we end up with 21,000 patients in this group of patients that use LTCHs in 2001 when we look at the 11 DRGs, and you compare that to 600,000 patients in market areas with LTCHs that use post-acute care. The higher cost of the LTCH, basically you don't see it as clearly as you would if these patients were more numerous.

MS. BURKE: Again, just taking it to the next step, because I think the analysis you're doing is exactly the right analysis. Do I understand you to suggest that you believe upon further analysis that we're likely to see a greater divergence in the per-episode cost between the two settings?

DR. KAPLAN: For the next analysis what we're planning on doing is making sure that cell sizes are the same when we do the multivariate analysis, so that we will randomly select from those 600,000 patients and compare.

MS. BURKE: But your fear is that what we're going to see is the cost that are essentially incurred as a result of the use of this particular method of delivery is in fact going to be substantially higher.

DR. KAPLAN: Yes.

MR. HACKBARTH: Given that it's less than 1 percent using the long-term care hospitals even where they exist, then this difference, this 12,000 versus 11,500, that may be very large, because the difference is diluted by including all the patients.

DR. KAPLAN: Yes, that's compare 1.1 million patients to 1.8 million patients.

DR. MILLER: I wanted to say this a little bit

differently. In a sense, looking at the with markets -- with and without long-term care hospitals -- is not the answer to the question of, are you seeing large differences. In a sense, the numbers on page 10 end up being kind of a distraction. We were first trying to go through and say, are these markets systematically different? Actually -- and I want to say this carefully to make sure this is true -- you are already seeing large differences in the cost inside those markets. When you look at a given severity level for a given DRG, you are finding large differences. So you're already finding what you are asking but --

MS. BURKE: But we don't see that here.

DR. MILLER: You don't see the numbers. What you see is -- it is in the tables of your paper, but the conclusion on page 15 is drawn from those tables that are in your --

MS. BURKE: I was trying to reconcile --

DR. MILLER: If you go inside the marketplace and you say, I'm now going to look at a person who used it versus didn't, in a DRG at a given severity level, you do in fact find a difference. Is that correct, Sally?

DR. KAPLAN: That's right.

MS. BURKE: So the 156 percent variance is what

you're seeing on a case to case, which is what is contained in the text.

MR. DeBUSK: Severity comes into play.

DR. KAPLAN: Yes. We are controlling for DRG and severity, because we are only comparing DRG-14 severity four to DRG-14 severity four. If you look at table 5-11 in your mailing material you'll see the mean total payment for five of the 11 DRGs. Basically the reason I picked these DRGs, since I was limited on the number of DRGs I could show on a table so that we don't have a chapter that's all tables, is that stroke and CHF are very common, hip replacement is very common, and then the two ventilator DRGs, because of number of these facilities that specialize in ventilators.

If you look at severity level four you see that patients who use LTCH, their total payment was over 36,000, whereas those post-acute users who didn't use LTCH had a case payment of 21,000. So there's a very big difference in the total payment. If the payment were the same we would not be concerned.

MR. HACKBARTH: Page 15 is comparing patients within the markets where long-term care hospital exist.

DR. KAPLAN: Exactly.

MR. HACKBARTH: So I guess that always creates the possibility that there's some selection process that's ongoing that isn't is captured by the severity adjustments and so on. Methodology stuff is way of over my head but it would almost be better to compare markets without long-term care hospitals with those that do.

DR. KAPLAN: We did that too. You just didn't see those results. We did do that. We compared and we found basically that you had the same kind of difference in total payment, and the same type of difference in length of stay in the acute hospital. Interestingly, when you add up the people in market areas who you LTCHs and those people who use SNFs, the proportion is the same up as the people use SNFs in market areas without LTCHs.

MR. DURENBERGER: Normally when I look at a map like this and see everything flowing to the South I think about the Civil War and how this is the Confederacy's revenge and all that sort of thing. But I have a different kind of a question as relates to the research as between the -- if I look -- let me just ask it this way.

Is it possible that you can look at this so-called other Midwest market, which is fairly new -- I mean, there's

one here in St. Paul which is, I don't know, somewhere in the late '80s. Then there's, it looks like Bismarck and Fargo, North Dakota, and Sioux Falls, South Dakota, and couple in Nebraska. If you took a part of the piece of the country like that, is it possible to do an analysis principally of the impact on the hospital market, whether it's the hospital market, the SNF market, something like that, of the arrival in a community like that of the long-term care hospital?

Do you understand the question I'm trying to ask which is, most of this is macro. Much of this is picking up Texas, Louisiana, a lot of concentration and then trying to make comparisons with traditional -- like SNF or hospitals and so forth. But I just am wondering out loud whether or not it's possible to take a different kind of a geographic subset and do some kind of an analysis there that --

MR. HACKBARTH: So before and after within the market?

MR. DURENBERGER: Yes, if that's possible. Or is it too complicated?

DR. KAPLAN: I think it is possible. I think it's actually outside the scope of what we've tried to do here, but it is possible. We actually at one time thought about taking

just Louisiana and comparing it to Oregon and seeing how different those two areas were, but then we got concerned about the usual representativeness of the data throughout the rest of the nation. But if that is what you would want me to do, we could do that.

DR. MILLER: I was going to say, our hypothesis here is that we don't think they're substituting for inpatient. We do think they're substituting for skilled nursing facilities. Another way to test it would require assembling some time series and knowing when they entered the market and saying, do you see the percentage of SNF patients changing between two years. Whereas right now what we're doing is we're seeing it geographically within marketplaces.

The only problem would be collecting a time series and identifying the markets where you had a big enough impact that you could tease something out. But we can take a look and see whether we could do something like that. Because a narrow case study may also help color some of this.

DR. STOWERS: Sally, I just had a question and this may get back to this SNF substitution as opposed to acute. But you said in the aggregate the length of stay was the same, but for these primary referral hospitals do we know if the length

of stay is shortened, or especially in these 11 DRGs is it shortened? Do we know how that varies?

DR. KAPLAN: We didn't really look at the acute care hospitals length of stay and whether it changed. We really looked at it on a patient level basis, by DRG, by severity level.

DR. STOWERS: That might give us a little deeper look into the substitution issues.

MR. FEEZOR: Sally, as I look at that map population obviously plays a little bit, but any correlation between certificate of need states and recent growth?

DR. KAPLAN: We thought we would put that in the multivariate analysis.

MR. HACKBARTH: Sally, if one of our main hypotheses is that long-term care hospitals are substituting for SNF care, I guess that then raises the question in areas where SNFs are providing the care is there anything different in terms of the characteristics of the SNF, the services that they offer, their financial performance, when they're picking this up as opposed to SNFs in states where there are long-term care hospitals that aren't substituting? If in fact we're were moving patients from one setting to the other, presumably the providers

organize themselves differently in terms of their characteristics. It might be interesting to know what the bottom line effect is for the SNFs then.

Any others?

MR. MULLER: What is roughly the payment rate differential between the SNFs and the long-term care?

DR. KAPLAN: The base rate for a long-term care hospital as of July 1 is proposed by CMS to be $36,000 per case. The SNF is a per diem rate so it's a little bit hard to compare, but I would say if you were guessing you'd say about $350 a day, let's say $300 a day times 20 days, 22 days.

MR. MULLER: That goes to Glenn's point about there's going to be a lot of cost absorption going on. Either there's a difference in severity or there's a lot of cost absorption going on.

MR. DeBUSK: We're talking about this here and not for one minute do I hope that we think that there's no difference in severity of these patients. You can go into an LTCH -- for the ones of you that haven't been in an LTCH, go in an LTCH and look at those patients. Then you go in a SNF and look at those patients. Folks, there's a whole different level of personnel taking care of these people, there's a whole

different level of quality. For one minute, to think that a SNF will substitute for an LTCH, there's no way.

MR. HACKBARTH: In a lot of states like my state of Oregon, there isn't a long-term care hospital so somebody is doing it.

MR. DeBUSK: Somebody is doing it. At what level is the quality is my question. Of course, we're taking these numbers here and I sometimes think you can make numbers look however you want to make them look, but just from observation there's got to be a whale of a difference. Now as you drill down, Mark, and get into the severity and the classification system and what have you, I would look for something to show up there. I have no doubt that perhaps there's a lot of things that both of them are handling now that could be handled in the SNF, but for those real, real sick patients that LTCH is really performing a service that is beyond a SNF.

DR. MILLER: The only thing I was going to say is that I agree with you. I think what we're trying to do is figure out what they're doing different and if those outcomes are different, and could you see that perhaps down the road once we've done further analysis if we can focus on what the mission is of these facilities that may be something that this

commission ends up commenting on. I think that's what we're trying to get at. In that sense, I completely agree with what you're saying. What are they doing? Which patients? And what do they do better?

MS. RAPHAEL: This is a completely different topic. These are my reflections on your chapter on monitoring post-acute care and your post-acute care episode database. I agree overall in terms of where you're headed with showing that the use of post-acute care has increased and there's been substantial declines in home health care; 46 percent decline for home health care only, 13 percent decline when it's combined with SNFs.

Where I have some concerns are when you move to say that the use of home health care has declined more for people who had a low probability of using it. First of all if you look at your data, actually there was a substantial decline even for those who had a high probability of using it, because people from the community, only 54 percent of those who had a high probability even accepting your methodology actually used home health care, 46 percent did not. So to me that dropped out of where you're headed, and I thin kit's important not to lose that.

I went back to Chris Hogan's study and I think he made some key points which I thought also were missing from your analysis here, because he says that the need for those people where the declines were proportionately larger, he said the need for post-acute care was less clear, or to be technically correct, less evident from the diagnosis present on the physician claim. And he says that the declines in post-acute care were highest for medical conditions, possibly indicating frailty, COPD, pneumonia, heart failure, et cetera, that had had a high proportion of home health care use prior to '96.

To me, that is a group where we really -- it is harder to clarify their need for post-acute care. It isn't as simple as a stroke; you need rehab. When you have congestive heart failure it is less clear from the diagnosis that you need post-acute care. I think, again, there's this dichotomy that's made which I think -- I was talking to Mark about this -- it goes back to the whole issue around the benefit, the home health care benefit and the lack of clarity about that benefit, and the attempt to make it a post-acute care benefit focused on restoration and rehabilitation.

However, it's really hard when you look at clinical

patterns to do that because people who have CHF go into the hospital on average two or three times a year, and then they come back out. You try to get them to a maintenance level and then they're going to have another acute exasperation and they're going to come back out. So it isn't as if for this particular set of frail patients you can make that clear dichotomy.

So I just don't want any inference in here that we really know that people who have a low need for care are the ones who actually dropped out of the system, because we really don't know that. We're making certain assumptions as to what underlies this decline, the change in venapuncture, the emphasis on looking at fraud and abuse, the attempt to really move and restrict the benefit. But I just think that it may be, if we looked at the over-85 population which tends to be the highest users of post-acute care, that there are a group of people who aren't getting this benefit, and maybe it's not all of the percentage that dropped off but it may be some percentage that really need this and have been lost to the system.

The other point that I think we need to look at as a policy issue is, you chart a shift from the use of home health

care to SNF. I don't know whether that's good, bad, or indifferent. I have no way to comment on that. But you have to ask yourself, from Medicare's point of view is this good public policy to send someone who has pneumonia to a SNF when that person could be cared for in the home health care environment? So I just think that whole issue of substitution of service needs to be looked at more closely.

MR. HACKBARTH: Carol, what I hear you saying is that are patients with certain diagnoses like CHF that it's not going to be clear that they all need home health but there might be a subset of them for which it's critically important.

MS. RAPHAEL: Right.

MR. HACKBARTH: Now if in fact fewer of those people are getting needed home health care, would that be attributable to the payment policy and design for home health, or would it be more likely the result of decisions about restricting coverage, or oversight activities where physicians are worried about certifying patients and then having somebody second-guess it?

MS. RAPHAEL: I think it's a combination. I think the payment policy is a contributory factor in the sense that the incentives now are to really take people with a defined

diagnosis and a predictable use. If I were going to really maximize my profits in the system I would want someone who I knew needed rehab for a certain amount of time and didn't need home health aid. That's where you want to really try to minimize your use.

Also, you want people whose use you can predict. You don't want frail elderly with lack of support in the community, possible cognitive impairments. These can end up being long stay, hard to maintain patients with an unclear discharge point. So I think in that way the payment system does lead you to try to look for things you can package and predict. The people who fall out are those who are harder to predict. But it doesn't mean they don't need the service. It's just that the payments lead you to try to carve those out to the extent you can. They also can be the medically complex.

So I think that's part of it. I think the other part of it is that when you look at a diagnosis it's hard to know sometimes whether someone needs the home health care or not. You get congestive heart failure, it's unclear; do they have a skilled need? They may not. They may need some monitoring by a nurse because of their complications.

So I think it's a combination of an attempt to really

clarify coverage as well as some of the incentives in the payment system.

MR. HACKBARTH: Any questions for Carol or reactions?

MR. SMITH: Carol, Sally, Nancy, we've talked about this question, the characteristics of or what has happened to the folks who dropped out. We've come back to it a lot. We often end up simply concluding that we don't know very much. Is there any way to get a handle, any of you, on the characteristics of that population and some attempt to take that data and try to make some judgment, Carol, about how many of these folks ought to be getting a service and aren't, or are and shouldn't?

All we know is this very large number, and your suspicion, which I suspect is right, is that they are complex, harder to predict, folks with multiple conditions and likely to be frail and expensive. But we don't really know that. Is there any way -- I know we don't have a data set that describes these folks because they're not in the system, but is there any way to get at some more understanding about characteristics?

MS. RAPHAEL: I'm not saying these people definitely need the service. I have no way of knowing that. I'm just

saying, I don't want to be facile and say that for all 46 percent of the high use people who dropped out that they don't need the service. I just want to step back and take a closer look at this.

DR. MILLER: I think you're going to answer the second half of the question and I just want to say something about the first half of the question. I actually do -- I want to throw a little defense out here. I think we do know more than we -- we used to think it was just a million and we knew nothing about it. I think actually the analysis that was presented last meeting and will be in the chapter actually is, maybe not a giant step but it is a regular step forward in the analysis. We took apart these episodes, looked at the shift pre and post, made assumptions about the acuity of the patients as best as we could and found patterns that one would expect.

I think what you're saying is that for a selected group of that population, the people who had chronic conditions, there may have been below that level a population that needs to be looked at. I think we can agree with that. But I don't want to just blow past the notion that I think this analysis was a big step forward in trying to understand what happened pre and post.

Now having said the easy part, I'm wondering if Nancy can say anything about trying to get inside that population. Is there any way to do that?

MS. RAY: Getting inside the population of people who dropped out? That's an area that I think Sharon will be coming back to you at the retreat and proposing to attempt to study that. I know she is particularly interested in trying to come up with a study methodology that we can try to look at that issue.

DR. MILLER: Okay, thank you.

Next is sources of variation in hospital financial performance. Where did Julian go?

In the interest of keeping things moving, Helaine, do you want to go ahead and do the final item on improved data, the agenda for improved data and then we'll pick Julian up at the end?

MS. FINGOLD: Good morning. This is the initial presentation of a product that we're hoping to do on an annual basis. It's an agenda for improved data on Medicare and health care. It's an effort to highlight data issues because I think the concern is that the data issues often don't get the emphasis that they really deserve. Sometimes they're brought

up in our chapters but sometimes they don't quite get the emphasis. Some people see them as technical or mundane, but in fact policy analysis that we complete and other policymakers complete are really only as good as the underlying data that we have.

Some of the issues we focus on in this paper are from previous MedPAC reports. Others are new. Again, most focus on specifically Medicare issues. In the future we're hoping that the scope might be broader.

This first issue we address has to do with monitoring access to post-acute care. Previous MedPAC recommendations in our March 2000 report requested that the Secretary continue to monitor access under the new PPS's. In fact the OIG was conducting surveys on access to SNF and home health services with reports being issued each year from '99 to 2001. However, those surveys were discontinued.

We did recommend in our March 2003 report specifically that the Secretary continue surveys of beneficiary access to SNF and home health services. We believe those surveys should be continued. That is what our recommendation was and we're reiterating it here. We believe the access information is important, not merely to monitor access, but

also in that MedPAC uses a lot of this data to assess the adequacy of payment rates. MedPAC itself is developing tools to assess access but we believe this information is important. One of which I think you were just discussing, the database on post-acute care again, but we think this is also equally important as a source.

The second issue is also related to home health. CMS has separate data sets on home health claims and patient assessment information. In that MedPAC is encouraging in another portion of this report, CMS efforts to move forward in quality, pursuit of quality in the system, we think that these two data sets, if linked, could provide some important information on quality outcomes. Linking the data sets would enable analysis of the relationship between service usage and outcomes.

Although CMS has begun to link these databases it's not really focused towards quality issues. We do urge them to move as quickly as possible in linking the databases but we believe they should, in addition to the way they are conducting the linkage, they should include information on patient assessment at discharge to allow for measurement of improvement of stabilization, and stabilization of conditions. So I guess

the way they've approached it up till now it really hasn't -- they're linking the information but not in the way that would best facilitate looking at quality issues. So we're hoping they'll pursue the linkages and do it in a way that we can use it for quality information.

The next issue is on physician practice expense costs. CMS currently uses what it calls a top-down approach to calculating practice expense relative value units. The data in the calculation have come from the AMA's socioeconomic monitoring system and information collected by CMS under the CPEPs, the clinical practice expensive panels. The CPEP information, CMS currently has a private-public effort to refine, to update. However, the AMA has discontinued its SMS system and the most recent data available are from '99.

So we're concerned if CMS continues to use the top-down methodology, and in fact the alternative methodology, the bottom-up methodology also relies on this data though to a lesser extent, that CMS needs to identify an alternate source for this information. We believe that one way to ensure the availability and integrity of the data would be to use a collaborative approach to identifying a new source involving CMS and another federal policymakers, the AMA and other

physician specialty societies.

Information on costs and charges of ASCs, again is a repeat of a recommendation included in our March 2003 report. Facility costs of ASCs are paid on a fee schedule. This aspect of the program was added in 1992. The initial rates for these facility costs under the fee schedule were set using survey data that was collected by CMS, though it was not required at that time by the law. The law didn't require that the survey be completed.

In '94, Congress added the survey requirement requiring that a survey be completed, the legal requirement that the survey be completed, and requiring resurvey every five years to update cost information and revise the facility rates. However, that survey has not as yet been completed. The most recent rate data available that the rates are based on is a survey from 1986. CMS did complete a survey instrument -- excuse me, they did complete the survey in '94 but Congress actually blocked implementation of those rates. So we're still relying on the '86 information. We think that it would be important for CMS to actually complete the survey to update the ASC information.

MS. BURKE: Do I not recall correctly that Congress,

and I think I remember reading this in the documents, Congress required them to do a post '99 survey, did they not?

MS. FINGOLD: I believe the post '99 was the resurvey.

MS. BURKE: To do one. And they have not done it.

MS. FINGOLD: They have not done it.

MS. BURKE: But was there not a statutory requirement that they do so, or was it simply --

MS. FINGOLD: There is a statutory requirement. My understanding is there was a survey instrument completed and that it has been stuck at OMB for --

MS. BURKE: Right. So the reason for their holding the rates, I remember clearly, was the fact that the data -- they viewed the data as being so old and required that CMS at the point do something more updated.

MS. FINGOLD: Do something more updated, right.

MS. BURKE: But that has not occurred.

MS. FINGOLD: Right, it has not occurred.

The next several slides and topics have to do with cost report data. We want to emphasize that cost report data is central to our ability and other federal policymakers' ability to understand and assess provider status and payment

adequacy. We think this is important information. We think the collection of it must be maintained. The data, we believe, must be timely and accurate, but both are really at issue.

There are concerns that the time for accessing the data has increased and in fact we don't have a good sense of how much that's increased but over time there have been issues about accessibility and we've addressed that here. Several years ago I believe our hospital update was delayed. We included it in our June report because we didn't have sufficient information early enough to get it into our March report, so we've addressed it ourselves.

There have also been public questions about the integrity of the data. CMS has been dealing with a large increase in responsibilities and often competing priorities in the wake of the BBA dealing with the lingering effects of reorganization and other resource limitations. It is our strong belief that CMS must continue to take active and public responsibility for maintaining the integrity of the cost report data.

MR. DeBUSK: What is the current age of that data?

MS. FINGOLD: I believe -- I should turn to Jack. What are we working on now?

MR. ASHBY: We worked in the March report this year with three-year-old data. That's the worst situation we've been in, and we've been in that situation about two years.

However, I think it's only fair to point out that that is gradually improving this year and if all goes according to schedule we should pick up a year this year so that when we look at payment adequacy next year we'll be two years behind rather than three.

MS. FINGOLD: So that's still a concern. So it's better than we have now but we still think --

One mechanism that has been proposed is the use of an early sample to facilitate access. CMS could require or pay providers to file, a representative sample of them to file early. However, CMS and the fiscal intermediaries would certainly need to commit to processing and auditing the information on an expedited basis. That way policymakers would be assured of data access. This is just an initial suggestion and we really need to explore all the ramifications of collecting an early sample to ensure that it was reliable and unbiased data.

We additionally believe that it's important for policymakers to have access to data on private payer rates. We

have had some of that in our analyses this year. We've looked at rates for physician services. We're hoping to look at some broader scope of rates but we think there needs to be a real comprehensive source of data on private payer rates. It would allow us to gauge factors that could impact the Medicare market but may not be evident from the currently accessible Medicare data, first of all because of the timeliness of that, what we just spoke of, but just generally even. It could help us, again, in assessing adequacy of Medicare fee-for-service rates. It could facilitate the use of competitive pricing by providing additional information. And again, we really need a consolidated source of that data. We believe FEHBP information could serve as a starting point for collection of this information.

In conclusion, we think there needs to be exchange of information among federal policymakers. In the future we may need a more formal mechanism to bring policymakers together, to have more active interventions and exchanges on these issues, to continue to identify issues to improve data analysis. We also believe that we want to be vocal in supporting CMS in its efforts to collect and process data. We think that CMS could use support in terms of money, technical input, flexibility in

contracting and hiring, and that these could facilitate their processing and collection of data information.

I'll take any comments you have and written comments on the chapter.

MS. BURKE: This is like the mouse that roared. I think our attention to this is absolutely critical, and I think it was a terrific overview. I think in some cases it actually understates the challenge that we face and the importance of this effort. In it you raise a number of suggestions, including creating an incentivized system to encourage providers to provide us data early. I think we ought to look at a whole range of opportunities, and I think we ought to not be shy about stating the need for support for CMS and the development of this information.

I think one of the challenges that we face, and certainly the Congress is in part to blame for all of this, although we were always the first ones to scream, is the lack of the quality and the current data that forces us into making assumptions about what costs are being incurred in the delivery of services undercuts all the credibility of the numbers. So that we end up in a debate over the adjusters instead of what the reality is.

I think that has gotten much worse, and I think the three-year-old data -- this last conversation we had on the hospital payment rates underscored how poorly informed we felt in doing this, and I think it is across the board. The ASCs was another example of just the hypocrisy of a system that pretends that we can guess based on 1980 and then moderately updated, that we've even close to reflecting what people are really doing.

So one, I think doing this is exactly right. Two, I think, if anything, we should even state more strongly the need to support this kind of information and look for ways to incentivize people to provide it to us or to access it. Finally, I think the suggestion in terms of doing the top-down on the docs rates, in the text you talk about turning to other organizations in a collaborative way, including the specialty groups, I think makes enormous sense. I think we ought to look broadly at getting information from organizations who have access to very current information that will in fact vary by specialty and out to be accomplished.

I think, again, the only way we're ever going to get buy-in is the sense that there is credibility to the information we produce. I think it was great thing to do and I

think we ought to be doing it every time, so I think the plan to do that makes tremendous sense.

DR. WAKEFIELD: Until that time when data are available in a little bit more of a real-time fashion I really like that notion of early sampling being done. I think, frankly, it might have been Joe Newhouse's suggestion. I think he's mentioned it on a couple of occasions.

Two questions about it. Have you had any -- just out of curiosity, any informal conversations with folks at CMS about the feasibility of doing that?

Then secondly, you raise a number of questions in the text about what stands in the way by way of barriers. One of the questions or points that you make is whether or not payment for early completion might bias the information that's reported. On that point, were you thinking that that bias would emanate from the difference between those providers who selected in to participate versus those who didn't, or were you thinking that somehow it would create a difference sort of bias? I'm wondering what prompted that question.

MS. FINGOLD: I think it was probably somewhat both. We just wanted to be sure -- again, with credibility you don't want to collect the data and feel like somebody could then

raise the question, because these people said they would participate or for some reason because they were being paid, that that would somehow undermine the credibility of the data they were submitting. I think we just wanted to be able to cover everything, to make sure that when we assess that the data would be valid. We want to look at it from every angle.

DR. WAKEFIELD: Any preliminary comments from CMS about this?

MS. FINGOLD: We haven't talked to the upper level. We've talked to several different groups, so it would certainly need to be a more comprehensive discussion with CMS about what this would entail. So yes and no.

DR. MILLER: Just on the bias. Sometimes the providers who are able to respond early may be systematically different than the other providers. I think that's probably the main piece that we're thinking about there.

MR. ASHBY: Could I add a clarification here that might add a tad bit of optimism to this? That is that we're not just talking about the ability of hospitals to process the data faster and CMS' ability to process the data faster on their end. We're also talking about a more basic factor and that is that hospitals in particular, really all of the

providers, have different reporting periods. So we're partially just talking about tapping into those that happen to early reporting periods versus those that have late. That, you would think, doesn't enter in as much possibility of bias.

However, having said that, I also in fairness have to point out that at least in the hospital data set we have noticed over the course of a number of years that the late reporters -- not the early reporters but the late fiscal periods tend to be slightly better performers on our measures of Medicare margins, and that's even after we attempt to control for teaching status, urban-rural, and that sort of thing. We've never really quite been able to figure out why that is. They just seem to be a little different for reasons unknown.

MS. BURKE: Jack, do I not recall that they tend to be loaded in July and October? Are there that many left in January?

MR. ASHBY: No, there's a number in all three. Almost all hospitals are in October, January, or July. The largest of the three is actually October, but all three of them are sizable, so that you are losing a good piece of the industry by not picking up those July ones. But for the effort

that Helaine talks about here, we can concentrate on the October reporters and make some significant progress there.

MS. ROSENBLATT: I want to echo what Sheila said about how important this chapter. I'm very pleased we're going to do it on an annual basis. But I also want to echo what she said, I think we need something in the introduction that really gets people's attention so that people don't think, this is just something that health care researchers worry about, but this is something that everybody should worry about.

On the subject of the cost reports, this is 2003. To me it is unfathomable that we are using three-year-old data, let alone two-year-old data. I don't think we are shooting high enough. Even the IRS is allowing online filing of income taxes. We should be asking for quarterly filing of cost report data, or something totally different. We talk about the Medicare program being a 1965 program, and I think in terms of the data how many billions of dollars does this represent and we're using two-year-old data? It's just crazy.

Having said that, let me now shift gears and talk about your recommendation of getting private payer data. You have about two, three paragraphs on that. The difficulty of collecting private payer data is --

DR. REISCHAUER: Quarterly.

MS. ROSENBLATT: No problem. We report it quarterly. I mean, it's there. That's the problem. I don't know if everybody heard Allen, the difference is due to benefit design, types of reimbursement. I really think you need to add a paragraph about how difficult it's going to be to get comparable data. Plus, we are competing on the basis of our deals with providers. If that information is made public, we lose all leverage, because the lowest price out or the highest -- the providers are always going to say, look, that one is paying a lot more than you. We want that rate. So that's a difficulty. The comparability of the data is a difficulty due to the wide range of benefit designs. I just think we need to embellish that, to talk about the difficulty of that.

DR. REISCHAUER: I'm going to repeat some of the stuff that Sheila and Alice said, and that was that there was like two sentences at the beginning to motivate this that were sort of geek kind of sentences -- you know, good data. I think what you want to point out that data is very important to the credibility of the program, to maintaining constructive relationships between providers and CMS. Right now there's a lot of confrontation based on the fact that data is old or bad.

And it imposes burdens on Congress because providers go for redress to Congress, when if we had better system a lot of that would be reduced. And it would allow Congress to identify emerging problems before they hit them in the face and have something more than anecdote to judge those on.

This is an undifferentiated list of things that we would want to do and I'm wondering if there's some way in a summary we could prioritize what makes the most sense to move forward on soonest? One dimension is, where would better data move large amounts of money around? When you have bad data and it's not been moved around, then it gets harder and harder to move it around when you have good data.

The other is, where are there the most egregious gaps, even though the money amount isn't great, between what in a sense should be paid and what is being paid that undermine the system?

Third, what's the cost of doing some of this? If we have a limited amount of resources, where should we be going? I'm not sure we can do all or most or maybe any of that between now and June, and this might be more how we look at this next year and the year after, but I applaud you and Mark for pushing forward on this initiative.

MR. DeBUSK: I have the same thought as Sheila, talking about the importance of this information. We've talked about this for as long as I've been on Commission. It's a major issue again and again and again. It looks like somewhere along the line somebody would bite the bullet and realize that the cost report as it is is old. It's outdated and it's inadequate. We've talked about are there other alternatives and we've gone all around this, talked about quarterly reports and what have you. There's real-time information and even the for-profits, they've got the information because they've got to report it quarterly. The non-profits, they're in a situation where they've got to know better what's going on. They're essentially in the same ballpark.

If we could go bite the bullet, go to a modified GAAP real-time it would solve a lot of problems. But it is beyond my comprehension how we can stick with this old cost report. It just doesn't make any sense whatsoever. Why can't we put somewhere in the chapter that a rework needs to happen, and we need to do this, and we need to move forward? What's to keep us from doing that? That's what we're supposed to be about. Let's make the big move.

MR. FEEZOR: Sheila started us off, I think on a

conversation that we had yesterday about the increased sense of urgency, and I think we were talking about who was more rabid in terms of demanding the kinds of data that we need, so I would echo that. I was going to pick up on Bob's point. I think we probably do need though, however, to prioritize what we think would produce the best outcomes for us to, or the best data for us to help guide Congress in this program.

The one other thing though I think I'd like to see us move towards, and that is making explicit a responsibility within or urging that Congress make explicit a responsibility of CMS to not only make available to leverage the data that they have relative to Medicare, but in turn to try to leverage that in getting access to some of that other data, perhaps private payer data or secondhand market data such as that we're investing in at CalPERS, where we're spending $12 million to begin to aggregate all of our four or five major payers' data into some sort of single format. Again, I think there is an opportunity there that needs to be more fully explored by CMS.

MS. RAPHAEL: I just wanted to follow up on the CMS issue because I think it would be helpful if you could tease out of this some of the comments you made. I wasn't entirely clear, if we had our wish list, what are the most important

things that have to happen at CMS for this to really change? You mentioned consultant use, some kind of flexibility. But I would like to have a better sense of what are some of the barriers at CMS and what concretely could we recommend and try to size and cost that could overcome those barriers? Because I think, as Allen said, they are pivotal to our success on this landscape.

MR. DURENBERGER: I just discussed, because it's not my field, with researchers in my community the proposal and they were all very excited and very complimentary of what I told them was the general approach. The one issue that they asked me to bring up does relate to private plans, and that is the decision by CMS last year to back off of requiring diagnostic code, limit the number of procedure codes by private plans, which at least they believe limits the amount of information that is available about exactly the procedure, what went on in the particular -- I don't if that happened or not. I'm just repeating what I was told.

MR. FEEZOR: In the risk adjustment factor in Medicare Choice?

DR. MILLER: I think that's what he's referring to, is that the decision was to scale down the instrument and the

data collection for the purposes of doing the risk adjustment. I think that's probably what you're referring to. That was in response to -- CMS worked at least a year-and-a-half with the industry to come to that conclusion. There were differences among the plans. Certain plans felt ready to do much more detailed types of reporting, and a lot of other plans were steadfastly against the detailed reporting. That's what led to where we are on the risk adjustment, if that's what you're referring to.

DR. WOLTER: Just a couple thing of interest to me. One is, when we look at outpatient hospital margins, I've heard the comment a number of times since coming on the Commission, that the negative margins are influenced by accounting practices. I'm wondering, especially with the introduction of the APC system and all the changes in these first two or three years, if there would be any way to put data together that would help us clarify that. I think it's confusing to people that we make update recommendations in the face of what appear to be significantly negative margins. If there are issues there, maybe part of our improvement in data would be to understand that better so we have a better sense of where we really are.

Also on the inpatient side -- and I may get over my head pretty quickly here, but my understanding is that as the DRGs are reweighted over the years that's done on charge to cost ratios, and that it's been some time since actual costs related to DRGs, there's been a study of that. I'm wondering whether in the universe of DRGs, since we're now introducing concepts such as covering the marginal cost of an individual DRG when we have transfer rule payment discussions, et cetera, whether at some point we should be looking at DRGs in terms of the actual margin around different individual DRGs. I raise this too because I think there are behaviors now, carve-out hospitals, et cetera, which may in fact be driven by realities of margins that aren't necessarily reflected in the way we look at inpatient DRGs.

Then lastly, on the cost report I'd just second some of what Pete said. In addition to more timely submission, are there changes in that that make sense? Are there non-allowed costs that should be looked at? The Commission may have discussed that in the past. I don't know. But that may be worthy of some attention as well. I know I just added to the list and prioritizing what's already there is an issue.

MR. HACKBARTH: I want to add my voice to those

saying that this is really important stuff. But I also agree that if year after year we just produce a laundry list, that the impact won't be what we want it to be. Assume one of the principal audiences for this is CMS and HHS, and in fact I think they probably would agree with many of the items on the list. The reason these things aren't happening is not that there is not the desire there, but something else is missing, in some cases perhaps resources. So I'd second Bob's suggestion, to the extent that we can establish priorities and have some method for thinking about priorities, I think that adds to the power of any suggestions that we might offer.

In addition to that, to the extent that we can talk not just about needs but also about solutions, innovative solution, perhaps lower-cost solutions, I think that too adds to the power. In fact we may want to think in terms of having the needs according to some priorities and in each edition focus on one of the highest priority needs and try to bring together some really good thinking about how it might be solved in a way that's efficient and least burdensome to all involved. Just a list though isn't going to have much impact on anybody.

Thanks for taking this on. This is important stuff.

Any other comments?

Okay, Julian. Last item for this meeting is sources of variation in hospital financial performance.

MR. PETTENGILL: What I wanted to do this morning is quickly give you an overview that covers four items. First is the concept behind this analysis. Second, I'd like to briefly review the preliminary findings that Kathleen Dalton and I presented at the last meeting just to remind you where we were. Then I'd like to talk a little bit about what we said we would do and what some of you asked for. Then lastly, I'll report on the new findings that we've added to the chapter in the interim.

Remember that the objective of this analysis is to identify factors that contributes hospitals' inpatient PPS margins and estimate the shares of the variation in margins that they account for. This is one way of evaluating whether the payment system is working and whether it's working the way you would expect it to.

Because that our focus and we're focused on margins that are affected by both hospitals' payments and their costs, we look at any of the variables that might affect either one, either payments under PPS or hospitals' inpatient operating costs, or both. We have broken the variables into two sets,

those that are part of the payment system and then hospital characteristics, and each of those has two subgroups. They're shown on the screen.

The payment factors include cost adjusters. That is, variables that are included in the payment system because they're intended to track the effects on providers' costs of factors that are beyond their control. These consist of things like case mix, the local market wage level, and other input price differences to the extent that they exist, cost-related portion of the indirect medical education adjustment, geographic rate differentials embodied in the base rates, and to some extent also the outlier and transfer policies.

The policy adjustments are given that name because they're not associated with cost differentials, but in fact they're included in the system to support other objectives. These include the portion above costs related to IME, the DSH payments, and some of the special payment provisions for rural hospitals.

Hospital characteristics include factors that have no effect on PPS payments, but they do affect hospitals' operating costs and are generally considered to be at least partially within the hospitals' control. There's two sets here. One is

environmental factors in the hospital's local market environment that are probably beyond their control, and then there are factors that represent hospital behavior and presumably are within their control. The environmental factors include variables that may reflect the supply of substitute or complementary services, physician supply, supply of other hospitals in the area, whether there are skilled nursing facilities nearby, and that sort of thing. The characteristics of the population living in the area, and things like income, and the age structure of the population, and so forth.

For the other hospital characteristics we have factors that may affect their costs like the scope and the scale of their operations, their occupancy rates, their length of stay patterns, and their relative pay scale. That is, are they paying wage rates that are above or below the local market rates.

At the last meeting we present some preliminary findings, and I'm just going to hit the grand highlights here. One was that after including the PPS payment factors and the factors that are partially within management control, we were able to account for less than half of the total variation. In fact it was about 42 percent. The payment factors accounted

for about one-quarter of the total variation. A part of that was related to problems with the case mix and the wage index adjusters, but the bulk of it was related to policy adjustments that Congress has included in the system.

Including the factors under hospitals' control, occupancy rates, wage policies, scale and scope of services and so forth accounted for about 8 additional percentage points of explained variation, bringing us up to around 35. Then adding the length of stay patterns, the ratio of actual to expected length of stay added another 7 percentage points bringing us up to 42. At that point we had not included local market factors.

One other thing that I think it's important to note it is three-fifths of the variation here is not accounted for in the analysis. If you look only at the PPS payment factors, three-quarters of the variation is not accounted for or not associated with the payment system. It's associated with something else.

At the end of that discussion we said we would add a few things or try to do a few things in the interim between March and April. These included adding the external environmental variables to the model, covering demand, supply, competition, HMO penetration and that sort of thing. We would

also try to examine the stability of the findings over time by looking at data for other years, and we said we would like to follow up on the length of stay findings because they're fairly powerful. What we wanted to know was what seemed to account for these differences between the actual and expected length of stay? Was it something about other factors in the local market or what?

Then a number of you made suggestions about additional variables that we should include. One of those was to examine the overall Medicare margin rather than the inpatient margin. The point of doing that was, recall that we found that hospitals that had other services like hospital-based SNF or a home health agency had lower costs and higher margins. The question arose whether that was the result of economies of scope or perhaps simply the way they allocated costs. Looking at the overall margins was offered as a way to distinguish between the two.

Bob suggested added hospitals -- pretty much in the same vein I think, adding hospitals' outpatient share. And David Smith suggested adding hospitals' Medicare share to the model, presumably on the argument that hospitals might be less sensitive to the PPS payment factors if Medicare was a small

part of their business. And Nick suggested looking at the case mix specialization of the hospitals.

Now we weren't able to do the third item; that is looking further at the length of stay ratio. The real effective analytic time between March and April is two weeks, so we didn't feel that we could do that justice. Similarly, with the overall Medicare margin, we have the data. We could have estimated it, but we felt what you're really lacking is the time to think carefully about what you see and try to interpret it. We just didn't have enough time to do that and all the other things as well. But for the others, we tried to do something on each one of them and that's what I'll talk about now.

First off, we added the external environmental variables to the model, quite a few of them, and they do add some explanatory power, about three percentage points. Some of them have interesting effects, but they didn't really change anything. The major findings still hold. The payment system accounts for about 27 percent of the variation, and case mix and wage problems account for a small part of that. But the bulk of it is still the policy variables, IME and DSH and the rural payment provisions. This is pretty much what we would

have expected I think.

We also added the variables that people were interested in. The outpatient share is associated with higher -- hospitals that have a higher outpatient share tend to have higher inpatient costs, which is not what you would expect. If what's going on is they're allocating their overhead costs to the outpatient setting you would expect the opposite. I don't know why that is. I think it's because it's picking up something else. It turns out that the outpatient share is highly negatively correlated with case mix, with the wage index, and with teaching, and with DSH, and some other things. So I think what's happening here is we're identifying a set of hospitals, mostly located in rural areas, that happen to have high outpatient shares and lower margins. So I'm not sure that it's a particularly meaningful finding.

Higher Medicare shares are associated costs and higher inpatient margins, which is, I think a little bit the opposite of what David was expecting. But I think it might actually be a fairly simple phenomenon in the sense that if you have a high Medicare share you really have to pay attention to what the payment system is doing, and you have to control your costs because there isn't anyone around to pick up the slack.

And you may have less flexibility in what you can do. I don't know that that's the explanation. It's just my speculation.

On the case mix specialization, we focused on cardiac surgery and orthopedic surgery and we identified the share in the MEDPAR data, the share of a hospital's cases that are cardiac surgery DRGs or orthopedic surgery DRGs. Then we tried to put that in the model. But what we discovered immediately is that they're both extremely highly correlated with case mix, overall case mix, which is no surprise.

So what we did is we created a couple of dummy variables and a single dummy variable that says that you are a niche hospital if you have cardiac or orthopedic shares in excess of the 95th percentile of the distribution of either one. We put that in the model and it's negatively related to margins. If you have a high share you tend to have a lower margins. If you're a niche hospital you have a lower margin. It's close to significant but not quite there. So it's the opposite of what you would expect.

Now remember two things. The 95th percentile for cardiac surgery is something like 14.6 percent of your cases. The 95th percentile of orthopedics is a little higher. It's like 18 percent. So being a niche hospital by this definition

is not all that exciting. It doesn't mean that you're really all that concentrated.

Second, we're talking about 1998 data, and 1998 data may just simply precede most of the niche hospital business in this country. So it doesn't mean that there isn't anything there. It just means maybe we can't see it.

You get a hint of that if you look at these little diagrams I gave you. This is the relationship, such as it is, between the share that is cardiac surgery and the payment to cost ratio for the hospital. It's all over the map. And the picture for orthopedic surgery is very similar. We broke it down by bed size, just to show that -- if you're talking about small hospitals that first picture has actually a couple surprises in it. I'm not sure I'd want to be in any one of them. Most of them are doing zero cardiac surgery, which is perfectly appropriate. But even when you get to the large hospitals, they're all over the map. So there just isn't anything here to show you.

Now the last thing we looked at was whether the findings held up over time looking at alternative years. We looked at 1992 and 1999 and the results were highly similar in both cases.

That's it.

DR. MILLER: I just want to ask this. In terms of the cardiac surgery and the questions that we've been getting on hospital specialization, this is talking about its relationship with the inpatient margin for the hospital in general. There's still a question outstanding below that of whether the DRG itself can be a profitable DRG. Just to the point that Nick has raised several times.

MR. PETTENGILL: That's absolutely right, there is that question.

DR. MILLER: To your question of the profitability of those procedures and the hospital specialization phenomenon I think there's still other questions and work to be done here. This is more the overall relationship to the inpatient margin.

MR. PETTENGILL: You can go at it both ways. One is at the level Nick was talking about where you're looking at the individual DRGs and trying to figure out whether they're profitable and to what extent, or not profitable as the case may be. Then the other way you can look at it is to look at the specialty hospitals and see what they're doing and then try to figure out, given all the possible motivations for forming a specialty hospital, which are quite numerous, which of them

seem to be actually operating. I think you have to do a little of both.

DR. WOLTER: Just a question on those graphs. It is all over the map obviously but it looks like there's a tendency to higher payment to cost ratios for the larger hospitals, or am just not looking at that right?

MR. PETTENGILL: No, you're correct, there is a tendency. But you have to remember that this is by variate, not multivariate so it doesn't control for the extent to which these hospitals are teaching hospitals, or they get DSH payments, or they're affected by any of the other things in the payment system that we know affect their margins. In that sense, I don't think it's surprising.

DR. REISCHAUER: But the graphs in the chapter, the charts with the lines, they do control for other things, don't they?

MR. PETTENGILL: If you're talking about the individual graphs where we're looking at variables one at a time, yes, they do.

DR. STOWERS: This may be an incredibly naive statement but I have watched over the last few years, especially recently, some hospital consultants at the community

level or maybe even smaller hospital level that have come in created dramatic turnarounds from very negative margins to very positive margins in these institutions. I'm just wondering if that would not be an interesting conversation to consult with some of them, like Stroudwater, that do a lot of this just to see where they saw the difference in management and other things that payment -- how was it weighted, how would they weight this as to payment versus management versus days in accounts receivable versus --

I just think it might give us a little bit more insight this other big chunk out here that we're not able to get our hands on. But I think chapter and all this is very interesting as to why some are having trouble and some aren't.

MR. PETTENGILL: Thanks. One of the things we tried to point out in the chapter is that there are parts of the dynamics of this that you can't pick up in a cross-sectional model that appear in the residual, the part you can't explain, because they have to do with changes in volume from year to year, for example. That's just one thing. You can have lots of other things go on in a market; a physician leaves town or retires, the management changes, the hospital is bought or sold. There are lots of things that can go on dynamically that

would affect margins as well, and we're not addressing them. But that's an interesting further item, I think, to pursue on our agenda is what's happening dynamically.

DR. STOWERS: I know some of them have very strong feelings about the differences in Medicare hospitals that are going well and those that aren't. There just might be some --

MR. HACKBARTH: Julian, how would you respond to somebody who looks at this and the percentage of the variation that's explained by these variables and concludes from that that the system is broken? That this is too random. There's just too much that we don't understand about who wins and who loses and we need a different mechanism, or we need a mechanism that at least reduces the profits and losses. Some people have said, there ought to be some sharing of the profits and losses so as to reduce the impact on both ends of the distribution.

MR. PETTENGILL: I guess I would say they're drawing what I believe is an incorrect conclusion from what they're seeing. Having controlled for all the factors in the payment system, and having controlled for differences in behavior as best we can, and market differences, there are still hospitals that are doing extremely well, suggests to me that a lot of what's happening here really is about how well you manage in

the circumstances you're in.

That's consistent with the case studies that we did in the ProPAC analysis going on 10 years ago, where following up on similar kinds of analytic efforts we sent a contractor -- Lewin in fact -- out it to look at hospitals in a couple of markets. That's the major finding they came back with, is that the hospitals that did well were managed by people who understood the market
they were in, and they had a good relationship with their physician staff, and they were doing a good job. The ones who were doing badly were managed by people who really -- they may have been very smart people but they had a bad relationship with their medical staff and they didn't understand the circumstances they were facing.

MR. HACKBARTH: I wonder whether it would be good to maybe carry a little of that, in a very summary way, into this chapter. I have had people who have listened to this or looked at the graphs that we've produced in our reports that show the wide distribution of margins and perhaps leaped to the incorrect conclusion that this is data that shows the system is broken. I'm worried that if they just see the graphs and the percent of variation explained that this will add to that.

Let's try to anticipate and explain qualitatively some of the other stuff.

DR. REISCHAUER: What strikes me as somebody who probably more than most of you, maybe not David, looks at cross-section analysis in various forms, I in a way objected to the use of the time we can only explain this amount. The explanatory power of this equation for what we're looking at I think is pretty darn good, especially when you think we're going across animals as opposed to lions. We're talking about little teeny hospitals in rural areas and Mount Sinai.

Sure, you throw in a few variables but this isn't like looking at gas stations across the country or anything like that. It's a very heterogeneous group of entities and what we're talking about in a sense is profit margins on a piece of your business and anybody would expect your cost structure not be driven, dominated by what's 30 percent or 35 percent of your total business, but maybe the other 60 percent by and large. So I'm really amazed that we've come up with as much explanation as we have.

If you had a group of economists looking at this stuff, no one would raise the question of, this looks like a random walk.

MR. HACKBARTH: The problem is the people who make the policy are not economists.

DR. REISCHAUER: I've noticed that problem too.

MR. HACKBARTH: Thank God.

[Laughter.]

MR. HACKBARTH: So I think we need to pay attention to the presentation in that sense and make sure that the context is well set.

MS. ROSENBLATT: Just on that point. I know when we were talking about risk adjustment, Joe Newhouse had done some work on what is a good amount and I think he had come up with, if we can explain 20 percent of the variation that's good. If there's a way to come out with a similar statement and say, 40 percent is good, I think that would be terrific.

One of my questions, and we may have discussed this last time but I don't remember, is given all of the attention on outliers recently did this analysis control for outliers? And if it didn't, do we need to come up with some statement about outliers? Because we're using 1998 data and a lot of stuff has hit in 2002 and 2003, and I don't want us to look like we're looking at the rear window.

MR. PETTENGILL: We're not looking out the rear

window. We're looking both front and back. We did control for outlier payments as a percent of DRG payments. That was one of the variables. It's not relevant or particularly relevant to the outlier situation at the moment, because it is 1998 data. A lot of the acceleration of charges that led to the extra outlier payments recently is a recent phenomenon. Some hospitals may have started that back as far as 1996 or 1997, but not very many did. So the bulk of the hospitals that are involved are not extraordinary in this analysis.

Kathleen did address it at the last meeting. She did take out the hospitals that had extraordinarily high outlier shares and it did change the results slightly making them, I believe, more negative. That is, the more outlier payments you have, the more negative the impact on your margins. That became more negative when she took out the outliers. I think for our purpose here that's all we really need to do.

MS. ROSENBLATT: I guess my point, do we need to put something in that takes this conversation and points out what's going on so that we look like, hey, we know what's going on?

DR. WAKEFIELD: Julian, two comments. Reading the narrative that we were provided before we arrived, findings on wage index, a couple of comments there. First, you indicated

that you're going to be studying that area further, that this wasn't the final piece on that issue. But if I understood, and I only did one quick read -- if I understood your findings correctly, you were suggesting that the labor share might be just about right for smaller hospitals but probably overstated and maybe quite overstated -- maybe I'm overstating that. You can tell me -- but quite overstated for everyone else. So about right on one hand and overstated on the other.

First of all, you didn't much comment beyond that so I guess one thing I'm asking you is are you intending to, are you holding your fire there because you're intending to do more analysis and then come back with some recommendations? Short of that I was thinking, what might be some of the things that one would do if we started to think about correction in that area, as realistic as that may or may not be to accomplish? But would one potential correction be that you recover those overpayments, if you will, plow them back into the base rate, or look at other options as well?

So I was just wondering, did you give any of that any thought yet or are you still too much, too early on the front end to do that because there's still some outstanding information that you're looking for?

Then the second area that I wanted to ask you about is, last time when Kathleen Dalton was here we talked about the part of all of this that's random and it seemed that, at least again for small hospitals, there was greater volatility, so less predictability, higher risk then to those small hospitals. In order to once again curry Bob Reischauer's favor, while we would never want to -- let me restate that. This is an ongoing project for me actually.

While one might not want to say, hypothetically, provide payment increases to somehow offset whatever problems exist for those small hospitals because of the volatility year to year, would it be reasonable to think about other types of provisions? For example, thinking about minimizing risk by not just moving to cost-based reimbursement but rather allowing for paying a mix of cost versus PPS to help to address some of that part of the equation, or is that all too premature to think about as well?

MR. PETTENGILL: I think you must be warming Joe Newhouse's heart at a distance. I'm sure he would be delighted with that suggestion. But I think you would have to consider a number of possibilities. If the problem is volatility and risk that is associated with that, then one possible way to deal

with it is to have a mixed system in which you are partly paid on the main system and then you're partly paid on a different alternative that takes the risk into account. Exactly how you would build something like that isn't so clear.

DR. WAKEFIELD: I say that because cost-based reimbursement makes it pretty darn tough to generate profit for those facilities that they can turn around and use.

MR. HACKBARTH: On the first issue, the labor share, we've proposed that it be examined and our hunch is that if you look at as a national average that the average labor share is too high at 71 percent. That, by definition, is a redistributive policy. So you had suggested, could we look at a mechanism that takes the excess payments from the ones that are being overpaid according to this analysis at the high end and give it to the low. If you change the labor share variable, it is by definition going to redistribute money from the high end to the low end.

DR. WAKEFIELD: Is that adequate to accommodate that?

MR. PETTENGILL: The implication of the analysis is -- there's several possibilities here, but one of them certainly is that the labor share is too high for some and too low for others. Now it's not urban-rural. It's according to the level

of the wages in the market. So it's okay. It's in the right ballpark, apparently, for hospitals located in relatively low-wage markets. That is, below one on the wage index. It's too high for hospitals that are located in high wage markets.

Now exactly what that means though is not entirely clear, because it could well be that it's not the level of the wage rate in the market, it's the size of the hospital. It just may be that it's too high for large hospitals that happen to be located primarily in high wage markets. We plan to do some further work beginning next month to try to sort that out. So absent any ability to say, this is definitely it, we don't want to do anything yet.

MR. MULLER: The go back to the broad point of how much of the variation is explained by the policy variables, I agree with Bob that getting 25 percent is quite good, especially given the 3,500 hospitals or so that we're looking across. But also from the point of view of MedPAC and other people with policy responsibilities, the fact that only 25 percent in that sense gets directly affected by policy considerations we make, it's something to note that there's a lot of things that are outside of control that affect the margins. So I think it's both important to note, as Bob

indicated in a preface, that in this is quite good by the standards of cross-sectional analysis. It's also probably a little frustrating from the point of view of how you push policy levers on a national program and that goes to the whole design. Both things are true. They're not mutually exclusive, and I think it's important to note that.

I have some factual things that I just wanted to check on. One is, Nick raised earlier in the comment on the data topic a few minutes ago, the outpatient question, and you referred to it as well. We've said in the past when we rationalize those high negative margins in outpatients, that's probably the result of more overhead being spread over there. I think in light of the findings here we may want to just reserve the comments for a while until we know that more clearly, because we have said that pretty consistently in the past. That it's okay to have those high negative margins there and not give the full update, or not give -- not the update, but to deal with the adequacy issue there. We basically always say the inadequate payments are overstated because the overhead is being spread over there. Since the findings here are not consistent with that I think we should at least temper that comment for a while.

Secondly, to go to the outlier question that Alice raised, it does indicate here that the outlier payments are negatively correlated with margin. Since there's a suspicion -- I like Bob's phrase that some people, the outlier, in some places they've gone on steroids and used it in a way that's inappropriate. Since there's a suspicion that the '02, '03 data would be different than '98, I would at least, understanding the limitations we've discussed all day today about dealing with old data, on the outlier question I think it's probably particularly relevant given the recent analysis of it and some major changes in it. So we may want to note that that may not be true there. Not that the '98 data is not accurate, but that it may have changed. Just a footnote that this may be one place in which things have changed. Not to pick one out of 100 areas, but given the fact that it's getting a lot of note and change.

I would also point out, given the discussion about niche markets and payments and margins on certain DRGs and so forth, there's a little inconsistency on page 5 and 6. It's minor, but where you say whether case mix and service mix are in or outside of management control. In a sense service mix, doing more cardiac, doing more neuro, doing more ortho is a

choice that people can make and some people think that's why people go into niche markets and specialty hospitals, et cetera. So I think in that sense case mix is also under management control. It's not something outside of management control. So I just think we should be consistent on that.

As you can imagine I was just shocked to see that we overcompensate teaching hospitals for IME. Now I don't want Mary to feel all alone so we should probably say we overcompensate critical access hospitals as well. You wouldn't want to be the only one that is not undercompensated.

MR. PETTENGILL: Actually, Mary is not at any risk because we excluded the critical access hospitals.

MR. HACKBARTH: You need a footnote that says, if we had included them, then --

[Laughter.].

MS. BURKE: Actually to a certain extent consistent with Ralph's comments, I was struck as well by the text discussing the presence of outpatient departments and home health services and its impact, and the suggestion in the text that that's an issue that you're going to look at more carefully and at greater depth I think makes absolute sense because it is counterintuitive to everything else that we have

thought. So I wanted to underscore that I agree with Ralph but I think we ought to be cautious about what we say in that broad context, and that we ought to look very carefully at that so we understand its implications, not only in the context of payment rates for hospitals, but as we look at these update factors for these other services.

The other point is really more of a longer term point and perhaps something we might think about this summer, or I would certainly benefit from a longer conversation about. That is the whole implication of these niche hospitals, and what ultimately that's going to do to us, and what that causes us to do in terms of looking long term at payment as we structure it. I think the fact that we're working off of '98 data underscores the fact that there has been a radical increase in the number and presence of these kinds of facilities in communities.

I'm not sure I fully appreciate nor understand the impact on community hospitals or on hospitals generally of having these pieces break off where people specialize in cardiac particularly or ortho. I think the data we have is certainly not adequate because I do think it's changed radically since '98. It does make me pause and wonder, thinking back to the old days and what brought us to PPS and

away from 223 limits and all those other systems is, does this call into question fundamentally how we've structured these payment rates over time? What the presumption was in building of DRGs and the associated assumption about how one on average did well because you were doing across a relatively broad range of services that would have goods and bads but on average that you would manage. That was the concept behind what we did.

That concept, to me, seems to be somewhat challenged when essentially you break off and do one thing. That is a fairly fundamental shift. Now we've broken it out when we did rehab. We've broken it out when we did other kinds of hospitals in the past. But the development of these kinds of units over time has caused us to new look at other ways of payment. But I would at least benefit from a conversation that is more in-depth about what the long-term implications are of these pieces that tend to break off, and what is that doing to our underlying presumption about the structure of a DRG system that assumes averages to a certain extent.

I don't get it, and I don't think the '98 data can really tell us even here, as good as -- I found the report, the chapter, Julian, to be terrific in raising these issues and moving our knowledge along. But I must say in that area in

particular I am quite confused as to what long term we ought to be doing and what we really know about what those implications are.

MR. PETTENGILL: I think it's a set of issues that we plan to pursue and we will be discussing it, I think, at the July retreat. It's clearly important for a lot of people for a lot of reasons. Whether it turns out to be practically important, who knows yet? I'm not sure we know enough to know that. But that some further work needs to be done on it I think is pretty clear.

MS. BURKE: You certainly hear anecdotally that there is an enormous impact in those markets where these units have been created. Again, I don't want to assume that the anecdotes that I hear from administrators who run those hospitals who suddenly had all their cardiologists move down the street to Cardiac Care For You, or whatever the unit happens to be, but there is enough of a stir that it has begun to concern me that I'm not sure that I really do appreciate what the implications are.

MR. HACKBARTH: Julian, yesterday after the meeting I had somebody ask me a question about this analysis. The analysis shows that margins increase with case mix, so that

hospitals that have higher case mix indexes tend to have somewhat higher margins. I was asked how that's reconciled, or whether it can be reconciled with the position that MedPAC took a few years ago saying that a case could be made that there needed to be some severity adjustment in the DRG system because we're underpaying the institutions that care for very sick patients. Could you just connect those two things?

MR. PETTENGILL: I'll attempt to reconcile. A couple of years ago we looked at adding severity distinctions to the DRGS and what impact that would have. The motivation for doing it was as part of the GME study where people thought that if you captured the differences in severity in teaching hospitals you would be able to fold IME and GME directly into the payment rates and solve the problem. It didn't work out that way, and the reason that it didn't work out that way is because if you break the DRGs down into severity subclasses what you find is that within any group you can name, within any region you can name, some hospitals treat patients who are more severely ill, fall into the higher severity categories, and some treat cases that are less severely ill than the current system captures.

So among rural hospitals we had some whose cases turned out to be, as measured by the APR-DRGs, more severely

ill than the current system shows. Similarly, we had others who were less severely ill. And the same was true of teaching hospitals, and large urban hospitals, and medium-sized hospitals, and you name it.

So what does that mean about the findings here? It's not clear. Because what we're seeing is that if you have a high case mix index it appears that that's making a contribution to margins that you wouldn't expect or want.

What that means at the individual DRG level, I don't know. It may not have anything to do with severity. If we had the same APR-DRG results now in the '98 data as we had back then when we used, I think it was '97 actually, there wouldn't be any relationship. There's something else going on. I'm not sure what it is.

MR. MULLER: Part of the conventional wisdom for many years was that the surgical DRGs, in a sense with higher case mix, and the medical DRGs had lower case mix, and there were a lot of comorbidities in the medical DRGs, and therefore there's more severity there that the DRGs didn't capture, and that would be a partial answer to Glenn's question.

MR. PETTENGILL: It's possible, but you can't know unless you do the analysis.

I guess I want to say one other thing. If I'm remembering it correctly, that analysis also showed that there were systematic differences on average. So even though among teaching hospitals I could find some that were higher and some that were lower, it's still true that the severity level at the margin for teaching hospitals was systematically a little bit higher than the severity level for other categories. So maybe that's what we're picking up. I don't know. When we estimated the IME coefficient in a cost function analysis using the APR-DRG data, so controlling for severity, we got a different coefficient. It was lower than the coefficient that we get with the DRGs, and that says essentially the same thing.

So it may be that these results are completely consistent with that, but I wouldn't know it unless I broke it down.

DR. MILLER: I didn't see them as necessarily inconsistent, that you could still be an issue of severity. Then also, Ralph's comment triggered this thought. It's not just surgical and medical and what's going on there. It's also how the hospitals choose to charge for those two different types of cases. Couldn't that also be reflected in this result?

MR. PETTENGILL: The relative weights are affected by hospital's charge structure. There's no question about that. I don't think it breaks out -- maybe on balance it breaks out between medical and surgical, but it's really based on the way hospitals mark up specific kinds of services. Even within a category like imaging, the markup on one kind of imaging is very different from the markup on another. That ultimately finds its way into the DRG weights because we use charges. One of the things we explored in that big GME study a couple of years ago was different ways to try take some of that out. I think we have some ways you could do that, but they're not completely successful because we can't get below -- you can't get all the charge structure differences out. There's just no way to do it, short of telling people, you have to charge within 10 percent of what it costs. Then you might get it out. But short of doing that, you can't.

DR. WOLTER: I think this is really a good point. We were talking about this the other day at my place and how we look at charges. If you have a high percentage in a given set of DRGs of Medicare patients you tend to be less likely to increase your charges at the same rate in areas where you might have a higher private commercial payer mix just because you

won't see a result from that. So as the years unfold, market conditions, other than just looking at your cost relative to Medicare payment, affect your decisions about charges. But that of course, then flows back into charge to cost ratios that weight DRGs, and that's's why this is so complicated in terms of how we look at where people make strategic decisions.

MR. PETTENGILL: Yes, I think that's right. I think the individual decisions that hospitals make are colored by the market circumstances they're in. There's no question about that. But remember that the charges we're using are the gross charges. They're not adjusted by the cost to charge ratio. We did that once. That was the original set of weights.

DR. WOLTER: I understand that.

MR. HACKBARTH: Okay, thank you, Julian.

Okay, public comment period. We'll have a brief public comment period.

Okay, thank you very much. I want to thank everybody, all the commissioners, and all the staff for the really outstanding work done the past year, and we'll see you in September.

[Whereupon, at 11:45 a.m., the meeting was adjourned.]