MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Wednesday, April 19, 2006
10:15 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. DeBUSK
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody. Welcome to our guests.

This is our last meeting in this annual cycle leading up to a publication of our June report. There will be no formal recommendations in the June report, and hence no votes on recommendations at this meeting.

Today we begin with a presentation on Medicare Advantage and special needs plans. Scott?

DR. HARRISON: Good morning. In my part of the presentation today I want to respond to some commissioner requests from last meeting for more information on benefits offered by the different type of plans and benefits offered in different areas. Jennifer will follow with a summary of our work on special needs plans and begin a discussion about the future direction of the plans.

One request we were not able to respond to was to compare MA payments with Medicare fee-for-service spending. Unfortunately, CMS has not yet released the plan-level enrollment data that is crucial to this analysis. We hope to get the data soon and will present the analysis in a forthcoming meeting.

Remember last time I described general plan availability and the availability of MA-PDs. This time I will show the availability of plans with specific cost sharing characteristics that beneficiaries may find valuable.

To recap, virtually all beneficiaries have MA plans available to them up from the previous high of 84 percent last year. Zero premium MA plans are available to 86 percent of beneficiaries this year, an increase from 58 percent. Almost three-quarters of beneficiaries will have access to zero premium plans that also include the Part D benefit, and 27 percent have zero premium plans available that include some coverage and meet Part D coverage gap.

As for the bidding that produced the availability, about 95 percent of bids were under the benchmark and thus almost all plans had funds to rebate to their members. However, the size of the rebates varied by plan type. Local HMOs tended to have much higher rebates than other plan types. They were followed by local PPOs, private fee-for-service plans, and regional PPOs had the lowest rebates. This means that, on average, the local HMOs submitted the lowest bids.

This time we examined two plan benefit characteristics that beneficiaries might find attractive. First we looked at total out-of-pocket caps for Medicare non-drug services. Such a benefit, which is not included in fee-for-service Medicare, limits beneficiary cost sharing liability for covered Medicare services provided in network. I want to make two notes about this type of benefit characteristic.

First, the MMA mandated that regional PPOs have such a cap. However, the law did not that specific dollar values for the required cap. We found that regional PPOs had limits ranging from $1,000 to $5,000 per year with $5,000 being the most common value.

Secondly, I want to note that some plans charge low enough cost sharing that beneficiaries would rarely, if ever, reach an out-of-pocket cap and therefore they don't bother specifying one.

We looked at plans that had a $,2000 or lower annual out-of-pocket cap. Sixty-five percent of Medicare beneficiaries have access to such a plan. We see that private fee-for-service plans with this limit are the most widely available followed by local HMOs. And while 88

percent of beneficiaries have access to a regional PPO with a cap, only 4 percent of beneficiaries have access to one with a cap this low.

For the second benefit characteristic we examined the expected cost sharing for an average inpatient hospital stay. An inpatient hospital stay is a relatively common and costly service in terms of cost sharing. In fee-for-service Medicare there was a $952 deductible for a hospital stay in 2006. Most plans impose a flat daily copayment and often have a limit on total cost sharing for a hospital stay.

Across all plans cost sharing liability for an average hospital stay varies from zero to over $2,000. We focused on the availability of plans with cost sharing of $500 or less for a stay because we view that level of cost sharing as a significant savings from fee-for-service Medicare.

In all, 87 percent of Medicare beneficiaries have access to a plan with expected cost sharing of $500 or less for an average stay. Availability of these plans is greater for HMOs and other local plans. Only 13 percent of beneficiaries have access to a regional PPO with this level of cost sharing.

At the last meeting some commissioners asked about urban/rural differences in benefits. We find that some of the more attractive benefits are more widely available in urban than in rural areas. Zero premium plans are available to about 89 percent of beneficiaries living in urban areas and about 65 percent of rural beneficiaries. Availability is also wider in urban areas for zero premium plans that include Part D benefits and for those include some coverage in the coverage cap. Plans with out-of-pocket caps of $2,000 or less are available to 65 percent of urban beneficiaries and 55 percent of rural beneficiaries.

And finally, 92 percent of urban beneficiaries have access to a plan that has a $500 or lower expected hospital stay cost while only 70 percent of rural beneficiaries have access to such a plan.

One of the factors in the differences between urban and rural areas is that benefits tend to vary by plan type, and while the overall availability of plans is similar in urban and rural areas, the types of plans available tend to differ. Urban beneficiaries are much more likely to have local HMOs and local PPOs available than beneficiaries who live in rural areas. Meanwhile, private fee-for-service

plans are more likely to be available in rural areas.

We know that the plans in rural areas are more likely to be the regional PPOs and private fee-for-service plans that do not generally have tight networks of providers and tend a bit higher than local managed care plans. Over 90 percent of beneficiaries have local HMOs or PPOs available compared with about 40 percent of rural beneficiaries.

We see, therefore, that the plans in urban areas, through the greater ability to build networks and managed care, tend to be able to bid lower relative to their benchmarks than plans in rural areas even though benchmarks in rural areas tend to be higher relative to local fee-for-service costs. As a result, the rebates tend to be larger in urban areas, thus allowing the managed care plans there to offer some more attractive benefits.

MS. PODULKA: You recall from past meetings that SNPs are a new type of Medicare Advantage plan created by the 2003 MMA. They're targeted to beneficiaries who are either dually eligible for Medicare and Medicaid, residing in an institution, or chronically ill or disabled. SNPs offer the opportunity to improve the coordination of care

for these special needs beneficiaries. Dual eligible SNPs, or any SNP that also covers Medicaid services also offer the opportunity to improve the coordination of the two programs.

SNPs function essentially like any other MA plan. In addition, they must provide the Part D drug benefit and additional services tailored to their targeted population. In exchange they are allowed to limit their enrollment to their targeted population.

SNPs are paid on the same basis as regular MA plans, including the same risk adjustment. This accounts for differences in expected beneficiary costs and therefore risk adjustment generally results in higher payments for special needs beneficiaries than for the general Medicare population.

The number of SNPs have increased quickly since they were created. This year the total number of SNPs more than doubled from last year with the introduction of 150 new plans. Organizations entering the SNP market include those with experience with Medicaid and special needs populations, such as Evercare, but also include MA organizations that have chosen to add SNPs to the menu of plans available to their members. Most SNPs, about 80 percent, are4 for dual

eligibles.

To describe how SNPs that have entered the market are taking advantage of the opportunity to better coordinate care for their members we chose to conduct site visits in four locations: Baltimore, Boston, Phoenix and Fort Lauderdale. As a whole, these areas show us SNPs in markets where there are many SNPs, existing plans converted into SNPs, dual eligibles passively enrolled into the plans, organizations offer multiple dual eligible plans, and all three types of SNPs exist: dual eligible, institutional, and chronic care.

Based on the information we've gathered so far we've identified a key concern about SNPs' ability to better coordinate care. SNPs, even dual eligible SNPs, are not required to contract with states, and in fact CMS does not consider or track which ones do. We found that few dual eligible SNPs receive payment from states to include Medicaid benefits in their package.

Because states financial responsibility for dual eligibles has been reduced over time, they may now have little incentive to partner with SNPs. This is in large part because prescription drugs are now covered under Part D

Medicare. This leaves Medicaid responsible for services like transportation, dental, vision as well as wraparound services and long-term care.

In addition, about one third of states have set their Medicaid rates at or below 80 percent of Medicare rates, which limits their cost sharing liability.

This leaves us with some questions going forward. Because most SNPs began operating just this year it's too early to determine whether SNPs result in improved quality and significant program savings. There is cause for concern about their ability to fulfill the opportunity to better coordinate care, especially to better coordinate Medicare and Medicaid.

We plan to continue to seek answers to, and would appreciate your comments on the listed questions. As SNPs are a new benefit package type we plan to continue to assist CMS and the Congress in defining what delineates these plans from other MA plans. To do so we will further evaluate plans that enter the market and describe their special characteristics. Institutional and chronic condition SNPs have a clearer target population and mission. The goal for dual eligible SNPs has been made less clear now that

coverage for prescription drugs has been moved from Medicaid to Medicare.

Finally, because of the rapid growth of new SNPs we plan to look at how the CMS HCC risk adjuster applies to special needs beneficiaries.

This concludes our presentation. We look forward to questions and any comments on future research.

MS. BURKE: This was very helpful. I very much appreciate it, and I particularly appreciate the following up on our series of questions, Scott, on how these plans differ and how they work. I have two questions that I'm interested in understanding.

One has to do with Scott's presentation. Scott, I appreciate that we can't yet do the cost analysis given that we don't have all the data but I continue to be interested, to the extent that we continue to see bids that are way below the benchmark, and it will be interesting to see how they vary against the benchmark, what that says about the benchmark, and getting some further understanding of how we're pricing. That will be something that, obviously, when you get the data I will be interested in continuing to understand.

And obviously it will vary urban and rural, but a further understanding of that because obviously the extent to which you don't have a rebate, you have less opportunity to provide benefits to populations, and that differentiation between urban and rural populations. I feel like I have to replace Mary as the ruralette, so just think like Mary does and come back prepared with those answers in her behalf.

The second question is this issue of the SNPs and the question of what it is we're trying to achieve with respected to duals. It would seem to me, although I'd be interested in my colleagues' view as well, it would seem to me that the goal here is not dissimilar from that that relates more broadly, and that is how you integrate services and integrate care for a population that are in fact quite at risk. So I am surprised to find in fact that so few states have chosen to utilize this opportunity and I'm interested in understanding what it is that they do with respect to this population. What are we seeing in terms of states and the coverage of the Medicaid services for these folks?

I understand now with Part D it's a slightly different mix, but nonetheless, Medicaid has traditionally

provided services Medicare does not provide for a vulnerable population. And if our goal ultimately is to have these people coordinated and treated in a way that essentially consolidates and organizes their services, the fact that the states are going in a different direction with that piece of it seems to me counterintuitive.

So as least philosophically my goal would in fact be to see more coordination. So I'm interested in understanding what the states are doing, why they're not going in this direction, and in fact what's happening with the management of those patients in those states where in fact it's not coordinated.

DR. MILLER: Was it clear from the presentation that some of the motivation for the states desire to coordinate here is changed because of the drug benefit?

MS. BURKE: Is it all -- because there are a whole host of other services that still -- what do we know about what's happening to these people?

MS. PODULKA: We don't have a complete picture of what each of the 50 states are doing yet. Because state benefit packages for dual eligible members differ, and because many of the key extra services have either been, as

in the case of Part D, shifted to Medicare, or perhaps reduced over time because of state budget pressures, we feel that there are many situations where states lack the incentive to partner with a SNP because they have so little liability right now for their duals, if that helps answer the question.

MS. BURKE: It doesn't. Well, it does and it doesn't. I shouldn't say that. I think we're presupposing that the states have little risk because they've essentially knocked out all those benefits, therefore, the individual is not any less well off under this scenario. But it would seem to me there is this broader question about how one coordinates services and there must be some aspect of the fundamental Medicaid benefits that remain that somehow are disconnected from our goal here to coordinate services.

So I think getting a better understanding of what is in fact happening in those states, how in fact they're providing whatever remains of the Medicaid piece, and how these patients are essentially experiencing the system will be very helpful, if we can get more information on that. And I think Nancy and Bill would like to comment.

DR. KANE: I was going to respond to that. The

Medicare senior care option plan in Massachusetts, which is a dual eligible with Medicaid involved, took approximately eight years to negotiate. So I'm just wondering if this isn't just the first step. You haven't really asked them about intention perhaps, but it takes a long time to get that Medicaid part built into it. So I'm just wondering if it isn't just a matter of time in that these are new and it's a new idea and Medicare is available but Medicaid may have to work its way in. So maybe we should ask the states or the plane whether they're trying to get Medicaid in.

MS. BURKE: It would be interesting to understand in that context, are the states with respect to Medicaid, going through managed care plans for other pieces? Are we essentially looking at two different contractual relationships and how ultimately -- because there was clearly a movement by the states towards the use of managed care for that population. So the question is,. are they doing that but doing it with different contracts? Is it their goal, as Nancy suggests, to ultimately coordinate because it is relatively new?

But it was clear that there was a movement on the part of states in this direction, that they had seen real

value in that kind of management of chronically ill and other Medicaid populations. And again, this is a particularly vulnerable population so some better understanding of that, because the goal really ought to be not to have these people not coordinated. That's the whole point of this. We've been fighting that for years.

MS. PODULKA: In the four locations we went to we did ask both plans and state officials about coordination. As Nancy mentioned, there are states where there's a long history of relationships between Medicaid and Medicare. That's working very well. There are other states where there's practically no history and they almost don't even know each other.

Many of the plans said that they were pursuing a partnership with the state but that there were obstacles so far that they had not overcome. However, I do have to say that there were a number of plans -- and I can't quantify this because obviously these are site visits and not like a survey. There were plans that for now were not planning on pursuing partnerships with states.

MS. BURKE: Do we know what the barriers -- do we have a sense of the nature of the barriers? Is it price?

Is it capacity? Is it networks? Do we know?

MS. HANSEN: Sheila, if I could add something to this. The PACE programs have actually been doing this for the past 15 years. I think the Massachusetts' experience of doing eight years of this, we're finding that it's like a zipper. In other words, what has happened is you have two sides of the -- the Medicare side and the Medicaid side and that goes all the way through from CMS Baltimore to the regional offices and so forth, and they are not accustomed to working together. So actually when PACE started to come was the first time the two parties came together.

MS. BURKE: [Off microphone] That's the whole point. That was when all principles behind PACE was his desire to --

MS. HANSEN: But the practical side has been this eight year gnashing of teeth before the zipper comes together. It also is this -- I think there is some text in this chapter about how complicated it is to talk about grievance and each system. So what's happened is if it's a small project many of the states historically, even before the passing of the Part D side, thought it was just not worth their effort. So it seems to be much more, certainly

from a pragmatic standpoint, stuck at the operational level, that the magnitude of change for the results that you get until there's enough momentum.

DR. SCANLON: Bringing up PACE I think is important because I have encountered a lot of confusion about special needs plans and I think in a lot of people's minds they are identified with PACE. I think they are going to be, very often, far from PACE. They're going to be much more like a regular MA plan and I think that's very important for us to make sure that people know.

In terms of the states, besides Massachusetts, besides Wisconsin and Minnesota -- AARP has done a recent report on states interested in moving towards Medicaid managed care including long-term care. So there's definitely interest in doing it but they're probably the exceptions rather than the rule.

In terms of what we're losing, I guess there's a question of -- there's gains from coordination but it's maybe along a spectrum. As you move from fee-for-service there's a clear gain if there's some organization that's going to be responsible for management. If you're in a MA plan, we would hope that that organization's coordination

would do a lot in terms of those gains.

Now if you're only paying for dental, it's less clear what the advantage of integration there is. Now if we start integrate acute and long-term care, then the coordination gains are potentially much different. How many special needs plans are going to be interested in taking on long-term care is a big issue? Even if states get active in this, are they going to find the participants on the plan side that are going to be willing and able to do long-term care? Because as Jenny can tell us about PACE, it's not just an issue of dealing with the two parts of CMS, it's and issue of pulling that off on the ground in terms of delivering that full range of services.

DR. REISCHAUER: A couple questions. One, do we have any idea what fraction of these new plans that have proliferated are sponsored by for-profit as opposed to non-profit organizations?

MS. PODULKA: I haven't split it that way but I can and get back to you.

DR. REISCHAUER: Because that might tell us something about what this marketplace looks like. I'm wondering whether there's lots of empty boxes, lots of plans

but no real enrollment in a lot of these.

And do we know whether the reluctance to combine the Medicaid with the Medicare is more from the plan's perspective or the state's perspective? Because I was thinking if I were setting up one of these things and this is the first year and I'm suddenly going to have a whole bunch of dual eligibles just to provide Medicare for, and I'm bearing some risk, this is a highly uncertain world. And then to throw in a whole other set of uncertainty, I think you'd have to be a very bold person to try to swallow that all at once, as opposed to say, a few years down the line I'll begin thinking about this.

You're talking about coordinating two different price systems and sets of expectations. Presumably these would be capitated Medicaid payments for a set of services that is smaller than the old set because drugs have been taken out and maybe long-term care is taken out, and the states wouldn't know what to do, and you running an organization wouldn't have the faintest idea what to do.

So I'm not surprised at all that when we look out, whatever it is, four months into the game that there's not a lot of these coordinated players.

MS. BURKE: Bob, to that point, I think it would be interesting -- I think you've done a very good job in the chapter of laying out what those challenges are. But would be interesting, because there are in fact a number of states who have chosen to contract through managed care plans for their Medicaid population.

DR. REISCHAUER: Mostly the kids and adults, not the elderly.

MS. BURKE: Right, but it would be interesting to see -- but they bring to the table some experience in working with the state. So it would be interesting to know whether or not where we have begun to see some willingness or some options, whether they in fact are the plans that have developed essentially some knowledge of it. As Jenny suggests, the negotiations over PACE were tortuous. And in fact, they're completely disconnected at the state level. As we always knew, the Medicaid guys never talked to the Medicare folks.

But there are now, recently, cases where Medicaid plans have in some of the more progressive states chosen to go in this direction. It would be interested to see whether those are the places that are picking it up because they

have some history, notwithstanding the fact that it's largely around moms and kids, and not the chronic elderly. But it would be interesting to see whether that experience lends itself to more likelihood of these people moving forward in these collaborations.

Because the concept of people, again, continuing to go forward and being managed by two entirely different systems is counter to everything we've tried to do. So the extent to which there's some progress or breaking down those barriers it would be interesting to see if that's where in fact we've seen that movement.

DR. KANE: I was just going to say, the dual eligible elderly population is mostly institutional. They are long-term care people. So it doesn't make sense to leave it out. In fact it's quite negative to think that's someone's managing the hospitalization benefit and is not managing the long-term care and frail elderly and the community-based, because you can really manage your inpatient very well just by dumping it all into Medicaid. So it doesn't make sense because most of those dual eligible elders are already in the long-term care system and that's where they need the coordination.

DR. WOLTER: Hopefully I'll be able to articulate what I'm interested in. I'm really interested in this link between the underlying fee-for-service payment and how the Medicare Advantage program and benefits and rebates unfold. When we see in here that the local HMOs in the urban areas have more rebate and tend to have richer benefits will we ultimately be able to be more explicit about the potential linkage of that too high underlying fee-for-service payments that allow bids that can come under that in a way that allows the 75 percent to come back and then enhance benefits?

Related to that interest I guess there is at least some concern that over time we may see rather significant inequities in terms of what beneficiaries have available to them over time based on that underlying fee-for-service payment and how it can drive the potential for plans to provide those additional benefits.

So I hope we'll be able to follow that to some degree over the next year or two and understand it.

We say in the chapter that it's more costly in the private fee-for-service plans, for example. I assume we mean it's more costly compared to the local county fee-for-

service payment. It may still be significantly less costly than what it costs to provide beneficiary care in other parts of the country. We may want to be more careful about the information in terms of how we portray that.

Then as we look at this linkage between fee-for-service payment and these plans I hope when we have the information we'll not look just at the local comparisons, but will there be some way to globally look at what is being spent in Medicare Advantage compared to global fee-for-service, so that we look at this blend in no way of the individual counties.

In other words, if there's enough bidding under high fee-for-service payment rates, does that offset to some degree those areas where there are floors that are above local fee-for-service rates? So that it will help us think through these issues about, do we want to peg ultimately the local county fee-for-service rate versus some more global way of trying not to be over fee-for-service rates? I hope I explained that well.

Then the other set of comments I wanted to make had to do with the provider community. I'm sensing there's a lot of confusion out there from providers about all this.

Of course it's still pretty new. It would be useful in the next year or two as this unfolds, to have more of a sense of how physicians and hospitals are responding to these array of products, and do they understand what's going on. I hear concerns that somehow they're going to be paid very differently than maybe is in fact the case.

In the critical access hospital community there's a lot of concern about how payment will work relative to the cost plus 1 percent that they receive under fee-for-service. So that would be, I think, something important to track.

Then the other thing that I've recently heard that was interesting at a meeting I was at that had a lot of physician groups, I've not heard so much talk about limiting access to fee-for-service Medicare recipients as I've recently heard. That's anecdotal. We haven't picked it up in any of the data that we've looked at from year to year on access. But there seems to be more discussion in physician groups about that.

On a other side of the coin, there are a few physician groups who feel that they would like to throw themselves into Medicare Advantage with the thought that somehow they feel they will be reimbursed more adequately

there. So that will be another interesting thing to try to follow if we can.

MR. HACKBARTH: On the very first point, Nick, I think there are two factors at work. One is, of course, the level of payment -- two factors affecting where the bids come relative to the benchmark and thus how many additional benefits are available to beneficiaries. One is the level of the benchmarks. The second is the type of plan.

One of the issues in the rural areas that is pointed out by the presentation is they have fewer local HMOs that are tightly managed and more of their Medicare Advantage opportunities are coming in looser network arrangements or private fee-for-service. So it's a function of both delivery system design and capability as well as payment rates.

DR. REISCHAUER: Just an elaboration on that point. I think if we look at this and say what our objective or goal in the long run is to make sure or assure that Medicare Advantage offerings in different regions of the country can offer a similar set of extra benefits we're going to head down a very complicated and probably a wrong path because this depends, to a certain extent, on what

Medicare is paying, the benchmarks. But it also has to do with the efficiency, economies of scale, which there's nothing you can do or should do really to compensate for market forces, how much competition there is, meaning what kind of discounts one gets, the restrictiveness of networks, and underlying costs and wages.

The unfortunate reality is, in certain respects -- or fortunate reality for some -- is rural and urban areas are different. The people in urban areas suck in pollution that the people in rural areas don't do, but rural areas don't have the same access to lots of services. It's hard to think of the Medicare program as trying to make adjustments for all of that.

DR. WOLTER: I don't necessarily have a point of view on what we should be trying to accomplish. I guess I just would like understand what does happen over the next couple of years with this because, very clearly, the fee-for-service variability in payment, is quite significant, is a factor in how this is all going to unfold. If that does lead to significant differences in benefits available to beneficiaries, it would be like to know that. And where that would lead us in terms of future policy I'm sure we'll

have different points of view.

DR. CROSSON: Just on that note and then I had another point, I would the second what Bob said. I think the last thing we would want to do would be to look at the situations in which the greatest deficiency leads to the greatest benefit and added benefits to beneficiaries and say on some level that's something that we have to correct for our or stomp out, because that was the whole purpose of prepaid Medicare in the first place.

I just had one point on the bidding process in the text that we had and that was on page 15 in the middle of the page where we go back and talk about the recommendations in the 2005 June report. It says the Commission recommended several changes to the benchmarks that would have resulted in lowering the benchmarks to a level equal to Medicare's local fee-for-service costs in each payment area, and I believe the recommendation was overall.

DR. HARRISON: We'll fix that.

DR. CROSSON: That's it. Thanks.

MR. HACKBARTH: Thank you very much. Next is a presentation on Part D formularies.

MS. BOCCUTI: First I'd like introduce Jack

Hoadley, to my left, from Georgetown University. He worked with colleagues from the National Opinion Research Center in Chicago, Elizabeth Hargrave, Katie Merrell, and Grace Yang, on an analysis of all the formularies that Part D had in place at the start of the new Medicare drug benefit. They took on a very large task and did a terrific job and he'll be reviewing his findings in just a few minutes.

I'll first mention a few of the objectives that we laid out for Jack and his team and then review some of the design rules that formularies had to follow at the start of the benefit.

So for the research objectives we asked NORC Georgetown to examine all the formularies and determine if and how formularies differ by plan type. So for example, do enhanced plans list more drugs than basic plans, do MA-PD formularies differ from PDP formularies?

In addition to answering these questions we also wanted this analysis to provide a baseline for our future work on the new Medicare drug benefit. As the benefit evolves we want to be able to track how plan formularies may affect access to drugs, Medicare and beneficiary spending and plan quality. So with enrollment data in the future we

can evaluate beneficiary choice regarding formularies and other plan characteristics. Then with claims data we can begin to look at how formularies influence access and spending. Then with all this data it will help us in developing plan performance measures.

One note that I'd like to make about formularies is that our data at this point can only examine the actual formularies; that is the drug lists themselves. It's important to remember that formularies give us some insight on access to these medications but they do not paint the whole picture in terms of definitive coverage. That is, a drug that is not listed on a formulary may indeed be covered through a plan's non-formulary exceptions process, which for some plans may be very informal and relatively easy while for other plans it may be more difficult.

Alternatively, drugs listed on a formulary may not necessarily be covered. For example, drugs that require prior authorization would not be covered without the plan's approval in most cases.

The next two slides list rules for formularies that are included either in statute or in CMS regulations or guidance to plans. I'll try to run through these quickly.

Regarding the therapeutic categories and classes that make up the framework for plan formularies, all formularies must be reviewed by CMS. So plans may design their own classification system or use a model developed by the U.S. Pharmacopeia or USP. USP reported that about three-quarters of Part D formularies use the USP model system for the initial formularies.

Plans must list at least two drugs, if available, per therapeutic class or category, and list at least one drug per key drug type. So just to give a quick example, a therapeutic category could be cardiovascular drugs; pharmacological class, cholesterol-lowering drugs. Then one more step down is the key drug type. An example would be a statin.

Plans must list all or substantially all drugs in six specified categories, namely anti-depressants, anti-psychotics, anti-convulsants, anti-cancer, immunosuppressants, and HIV/AIDS drugs.

Plans were told that they should only list drugs on a non-preferred tier when therapeutically similar drugs are available on a lower tier.

Plans may have a specialty tier designed for high-

cost drugs; for example, biotech products.

The important issue to know about specialty tiers is that plans do not have to grant any cost sharing appeals for drugs on that tier, which for the most part are at about 25 percent coinsurance. So the drug listed on a specialty tier is covered but a beneficiary cannot appeal for the drug to be covered at a preferred cost sharing level, which they can do for non-preferred tiers.

For 2006, CMS did not explicitly define what drugs could or could not be placed on a specialty tier. But for 2007 CMS is exploring a price threshold for this tier of over $500, so drugs under that amount could not be placed on the specialty tier.

An overriding general rule for formulary design is that plans may not discourage enrollment for certain beneficiaries. That goes for their classification system as well as the drugs they list on their formularies. Plans may use utilization management tools, such as prior authorization, and plans must have an exceptions and appeals process for obtaining non-formulary drugs and more preferred cost sharing as I just mentioned.

Finally, plans had to develop transition policies

for beneficiaries who were stabilized on a therapy before enrolling in a drug plan. Plans have to allow beneficiaries time to switch over to formulary drugs and CMS guidance extended this time to 90 days.

The last item that I want to mention before I turn it over to Jack is that it's trickier than you might think to determine how to define separate drug products. USP and CMS did not define differences between drugs so some questions arise when reviewing whether formularies actually meet all the criteria that I just listed.

So now Jack is going to tackle that issue and review the results.

DR. HOADLEY: Thank you. I'm pleased to have the chance to present the results of these findings to you.

As Cristina said, one of the challenges methodologically is this question of what is a drug. It seems like that should be a straightforward question but it really isn't.

What definition of drugs should we use? We could think about the NDC code level. But the NDC code, as you may know, represents every single separate form, strength, package size, manufacturer of a drug gets assigned a

separate NDC code. So working at that level of detail is not really the way you want to go.

In addition, plans were not even required to file every single NDC code they covered in the files they submitted to CMS. So our basic database would not be complete at the NDC code level.

Then you can go to the chemical entity level. What is the drug that we think of as the drug? Even that is in an ambiguous concept because there's an extended release version of fluoxetine, the weekly dosage of fluoxetine, Prozac, a different chemical entity than the regular single dose. We can also think of the difference between the brand and the generic version of the drugs, which is important. For some purposes you only care which chemical entity you're working with. Other cases you may care whether a brand version or a generic version is covered.

The point is we need to have a consistent metric that we use for the analysis to make our analysis consistent across the plans, and that's what we've tried to do, and I'll show you in a moment. But what we've come up with may not be exactly the same metric that any other study might do, so there are going to be different answers by different

analysts coming up with different methodological definitions. We think that this is one of the first studies to really extensively use the full CMS file, public use file of all the formularies and so we've tried to do a comprehensive analysis in that regard.

The next slide shows you a little bit of the complexity of what we tried to do. The box on the left illustrates, obviously in a very simplified way, a set of NDC codes that might be listed. As you can see there are different dosages, there are extended release versions, there's different manufacturers perhaps represented on this list.

So what we do in trying to collapse these is take the NDC codes that represent a particular chemical entity and collapse those together and indicate that a drug is covered if any one of the NDC codes in that group that groups together as drug A or drug B or drug C or drug D is covered. But the box on the upper left works at that chemical entity level. We're not so concerned at that point whether there's generic or brand versions. Some drugs have generics, some have brands, some have both,. but we've got a total of four chemical entities in this analysis. That

might be the right analysis when we're looking at things like whether CMS guidelines are met, where we don't really care whether Prozac is covered or the generic fluoxetine is covered.

The boxes on the lower right corner of the diagram indicate what happens if you start to look at the separate products that a consumer might think of where you care about the generic and brand differences. So there's generic drug A and brand drug A. There's brand drug B, doesn't have a generic version. Brand drug C doesn't have a generic version, and D is available only as a generic.

So that gives you an idea. So that's perhaps that way you might look at this when you're looking from a beneficiary access point of view or when you want to think about the cost sharing differences that would exist between brand and generic drugs.

The other methodological issue we needed to think about was the tier structures, and could we come up with any way to standardize some of the tiering. As you may know, the MMA gives the plans flexibility to create cost sharing tiers within the bounds of actuarial equivalence, although of course the standard benefit simply provided 25 percent

coinsurance across the board for all drugs. Many plans, as you'll see in a moment, chose to use cost sharing tiers, and our analytical goal here was to try to standardize the tier designs as much as possible. So our principle was that where plans label a larger number of tiers but in fact applied the same cost sharing and other rules to those tiers, we combined those into a single tier.

On the next page you'll see how that works. This is a hypothetical plan that has, for example, two generic tiers, a preferred and a non-preferred, that they list out in their formulary. But in fact both of those tiers are charged at the five-dollar level. So effectively for the consumer there's no difference between those tiers. Those may have been distinguished for administrative reasons, they may be something that the plan uses in its commercial business and just left it in place nominally but decided to charge the same cost sharing. We don't really know why. But for our purposes we treated those as a single G tier.

In this particular example there's a preferred brand tier and a non-preferred brand tier. Those are at different cost sharing levels so we leave those as separate PB and NPB tiers. So you've noticed we've assigned letters

to the tiers rather than the numbers that you typically hear.

Finally, the specialty tiers. In this case, the plan had a specialty drug tier with 25 percent coinsurance and it had an injectable drug tier at 25 percent coinsurance. Again, those appear to be indistinguishable so we combined them into a S tier. It may be that for purposes of the appeals exception that Cristina mentioned that that's only intended to apply to one of those two tiers but there's no public labeling of where that applies so we can't make that distinction. So as far as any information we have, these are indistinguishable tiers. So what appears to be a six-tier plan actually we treat as a four-tier plan.

This begins to give you a little data on what we see out there. Basically this is asking what tier structures are the plans actually using. What you'll see here is that the modal category is the most common tier design that plans seem to be using is the three-tier structure of generic, preferred brand and non-preferred brand plus a specialty tier. So in effect, a four-tier structure. That's the most common pattern both on the PDP side and on the MA side.

Others that are common include the three-tier structure without the specialty tier, or the generic brand structure with a specialty tier on the PDP side.

What we also can see in this is the majority of plans did choose to adopt specialty tiers, about 60 percent on both the PDP and the MA-PD side. Generally PDPs and MA-PDs look pretty similar but MA-PDs were a little more likely to use the three-tier structures and a less likely to use the two-tier structures with or without the specialty tiers.

The next chart looks at where the drugs are listed. So what we've done here is divide up by the different tier structures how many drugs are listed. What you see here is that the plans with the three-tier structures, with or without the specialty tier, and the plans with the standard 25 percent coinsurance design, are the ones that have a few more drugs listed.

The differences are not enormous here but there are definitely differences. What we think is going on, although we haven't been able to have enough time to go deeply enough in the analysis to really say this, what you can see clearly on this is the differences on the brand side. The ones that add the third, the non-preferred brand

structure, have more brand drugs.

So what we think they're doing is when they add that third non-preferred brand tier they're adding additional drugs to put in that tier. They may be shifting some drugs from what would otherwise be the single brand tier, moving them from preferred to non-preferred status. But what they appear to be doing is adding more drugs. Similarly, the ones with the standard 25 percent benefit seemed to have a broader list of drugs on their formulary.

But what we do see clearly is that almost all plans are at least restricting the list from what would otherwise be the universe of drugs, although the concept of the universe of drugs -- going back to my what is a drug question -- is not necessarily a well-defined concept here.

This chart gives you an answer to a couple of interesting policy questions. The first is, do the plans, do the PDPs that had a lower enough premium that they were authorized for auto-enrollment of the low-income subsidy folks and the dual eligibles, do they have a different size formulary than the plans that were not eligible for auto-enrollment?

The answer is there's only a slight difference.

The plans without auto-enrollment have slightly longer lists of drugs on their formularies, but the difference is really quite modest. So for the most part it looks like the dual eligibles and the other low-income subsidy folks got to enroll in plans that had roughly the same number of drugs listed on their formulary as the plans that they weren't eligible for.

A similar question about the basic plans versus the enhanced, the ones that went beyond the actuarial value to enhance their benefit in some way. Again, the differences here are very slight. For the most part there's not a longer formulary listed for the enhanced plans than for the basic plans. On the MA side you see a slightly larger list but the differences, again, are quite small.

Again what we think is going on here is that the difference between basic and enhanced plans falls in coverage in the coverage gap, perhaps less likely to have deductibles, lower cost sharing levels. The differences is in the benefit design around the cost sharing not in the size of formulary. In fact some of the national plans use identical formularies for both their basic plans and their enhanced plans.

This slide goes to the question of so the PDPs and the MA-PDs list about the same number of drugs or not. If you focus just on the top four bars, the PDPs, national and non-national, and the local MA-PDs, both the HMOs and the PPOs, what you'll see is pretty similar formulary sizes. They list about the same number of drugs. You see some differences between the different types of -- the local PPOs have slightly larger formularies than the local HMOs. The non-national PDPs have slightly larger formularies than the national PDPs. I would note here, when we say national it's not just the 10 national organizations but the additional organizations that have offerings in nearly all regions.

The only real exception here are the very small sets of plans that are the regional PPOs and the private fee-for-service plans that seem to have substantially larger formularies. We're not completely sure why that's the case. Obviously, the regional PPOs is a relatively small number. The private fee-for-service plans may be simpler going on the principle of covering everything the way they do in their rules for networks for providers. There's also some difference in the payment structures that apply to these plans and perhaps that's a factor as well.

But I think the overall finding here is that the PDPs and the local MA-PDs have similar kinds of formularies here.

The last couple of slides relate to the use of utilization management tools. Let me remind you that the two utilization management tools we're looking at here, prior authorization where the physician must show that a drug is medically necessary before the plan is going to grant authorization to dispense that drug, and step therapy where the plan will restrict coverage of a drug unless or until other therapies are tried first. So these are two of the management tools that are flagged in the formulary files.

We asked two questions here. What proportion of plans ever use these tools? And then, for the plans that use them, what is the percentage of drugs for which they're used?

What you'll see here is there's not much difference first of all between PDPs and MA-PDs, but there's a lot of difference between the use of prior authorization and step therapy. Prior authorization is used by nearly every plan. Where they use it, they use it for a relatively

modest subset of drugs, about 9 percent of their drugs.

The step therapy on the other hand is much less commonly used. Only about a quarter of the PDPs and about a fifth of the MA-PDs use step therapy at all. When they do use it is used for a very small number of drugs, less than 1 percent of their drugs.

The next slide basically slows you though how this can vary by drug class. These tools are really used very selectively and very differently in drug class. Let me just emphasize two of the classes here. You can look at the others on the slide.

The top row, the opioid analgesics, the pain relievers, prior authorization is used on only about a tenth of the drugs in that class. Again, we haven't gotten into all the details of exactly which drugs but you can imagine here it's the Oxycodones and the hydrocodones that are subject to abuse that might be subjected to prior authorization to make sure they're legitimate prescriptions. And none of the drugs in this class had step therapy there be involved.

If you looked then in contrast at the last row of this table, the proton pump inhibitors used for ulcers and

GERD, all of the drugs in this class have step therapy applied. Here's a class where typically the rule is that you've got to try some of the less costly remedies, the H2 blockers, for these ailments before you move onto the more expensive PPIs, or perhaps require you to try to use the over-the-counter Prilosec before moving on to some of the prescription versions of the drugs.

Same thing with prior authorization. Half or three-quarters of the drugs have that, presumably for some of the same motivations. You'll see some of other classes that are different. So what you really are seeing is a very targeted and hopefully a very clinically appropriate use of these kinds of tools, attempting to target them where there's clinical justification or abuse questions or other kinds of reasons why they're needed in these particular instances.

That's it.

DR. MILLER: Can I just say one thing before we do this, and this is unscripted. I think the way for the audience and for the commissioners to hear what's going on here is, we have a lot of work ahead of us on the drug benefit, and the formulary is the heart of that benefit.

Step one is -- and we had some of this exchange with I think Jay and I in the last meeting -- is how are we even going to construct the framework that we're going to use to look at this? And how somebody can get to a drug is the number of drugs, what tier it's on, is there any kind of utilization management, appeals exemptions process? So this is us trying to come out of the blocks. Jack and his crew have done really good work in helping us build the framework and begin to get the initial look on it. That's the context. Then this will drive much more of our analysis of the future.

DR. NELSON: A question and comment. I will do them both at once.

The question is, do you have any idea how the formulary size, number of drugs covered, compares with other large purchasers such as the VA or the military, in terms of the number of drugs they cover in their formulary?

My comment is, one of the things that will be important to track is how burdensome and time consuming the appeals and exceptions process is. Because we are hearing from physicians where they have to get prior authorization and it takes them an hour to do it. They have to fill out

15 pages of a request in order to continue a person on the drug they've been on for years and so forth.

DR. HOADLEY: To answer your question, I think we do not at this point -- we're not able to say how the size of these formularies compares with things like the VA or commercial plans or anything else. The first challenge in doing that is the methodological question, what is the drug? We'll have to go through the same kind of processing of those files to make sure we're really comparing apples to apples before we can really make that kind of statement.

MS. BOCCUTI: I'll mention also that we did look a little bit into the grievance and appeals process in the June chapter last year and tried to talk to plans about how that's carried out. We also spoke with physicians. But we'll want to be looking at that in future. And I think CMS is interested in that too.

MR. SMITH: Jack and Cristina, thank you.

Jack, I wonder, what do we know about -- we've got some sense of how many drugs. But what's the standard deviation? How many drugs are on everybody's formulary? And is there something important about the drugs which are missing? Or once you get to the third tier of a three or

for-tier plan maybe it doesn't make any difference because you put anything in and impose a high copayment.

But is there something useful to understand therapeutically about the difference? Are the missing 100 drugs important, or is that a market --

DR. HOADLEY: We haven't gotten deep enough in our analysis to answer those kinds of questions definitively but I think I can offer a couple of insights. One is on the question of how much range there is. We did have some numbers -- I don't have them right in front of me, but there's a pretty substantial range among the plans of the size of the formularies. I know for the other analysis I did for the Kaiser Family Foundation on a much smaller set of drugs we saw coverage rates between about 60-some percent then maybe about 85, 87 percent among the plans and that was for a smaller subset of 152 drugs. We definitely saw a similar range in the analysis we did here I just don't have the numbers right on the top of my head.

I think the really interesting question you're getting into is what sort are the missing drugs? One of the things that we just have started to do and want to get more into is really looking at class by class. It's a big

difference if you're leaving off drugs in a class like the anti-psychotics. Obviously the rules there say you basically can't leave them off and that's pretty much what you find there. But there you're going to see close to 100 percent coverage. Where you don't see completely 100 percent it's because of generic and brand versions, if you're counting that way, or different variants, extended release versions or things like that.

When you get to perhaps respiratory tract products where there's a lot of different product that all do the same thing, or some of the ARBs for -- there's seven ARBs for hypertension -- many plans chose to cover two, three of those seven products. The rules simply say you have cover one. It's a key drug type. And many plans came close to that smaller number because they feel they're all equivalent products and people can appropriately choose between them.

So I think as you get into the class by class analysis is where you get the more interesting analysis on that.

DR. CROSSON: I'd like to comment on a place in the text again but in this case it speaks to Mark's point which is our evolving sense of purpose here, what it is this

piece of work is about. Towards the beginning we talk about the fact that Part D is a major departure from traditional Medicare in the sense that the benefit is not defined, it's rather left to the plans to determine. This approach has the advantage of providing a range of plan options that could potentially better suit individual needs but also raises concerns about whether beneficiaries will enroll when faced with many choices.

It seems to me the major concern it raises is the question of whether the plan design has the effect of creating selection bias. Or to use the terminology that the guideline uses, discouraging enrollment by certain beneficiaries.

I suppose you could also apply that, I hadn't thought about it particularly but I suppose that principle also applies to the use of utilization management techniques. It seems to me that if we can provide value over time here it would be to look at, I mean catalog what's so going on, but also look at the patterns over time from those two perspectives. And probably it would be worthwhile calling that out right in the beginning.

DR. MILLER: I agree and I think the other thing,

just what we're talking down the road and I think we've said this in the last meeting as well, you can also eventually get to the analysis of which plan's designs can distinguish on the level of, or different patterns of utilization, total expenditures per beneficiary, are there quality differences, just to carry that thought further out. But we'll make sure that the chapter's written that way.

DR. REISCHAUER: The first point is to elaborate a bit on what Alan mentioned, and that is to be useful we really have to have some reference point or else you're comparing what Part D offers to some ideal, which is offer everything and give it away for free, I think which is a set of expectations some have. It strikes me the appropriate reference framework would be what people had before. But that's history and there's no way to get it.

I wonder if we know anything about what formularies and arrangements look like for those who have retiree policies that are being subsidized through Part D and how generous, restrictive, whatever, they are compared to the situation here as opposed to the commercial insurance for those under age 65. These aren't questions but just observation.

I would think it is absolutely impossible to figure out actuarial equivalence. I mean it's an ambiguous concept to begin with. If everybody's structure was $250 deductible, 25 percent coinsurance, some of the analysts could sit around and roughly come out with some notion of is this actuarially equivalent. But they aren't. They're designed that are all over the lot.

What is CMS doing? I would think there must be a huge range here in what it is willing to approve as an actuarial equivalent, by necessity.

MS. BOCCUTI: You mean considering the formulary variation, how that plays into it? Is that part of your question?

DR. REISCHAUER: No, you have tiers, you have different coinsurance rates, you have no deductibles in some. In theory what you're trying to do is produce cost sharing that is equivalent to what somebody faced with a $250 deductible, a 25 percent coinsurance, and some array of drugs, would spend.

MR. BERTKO: Let me try that and I'll try to give you my interpretation of what I think CMS has done on that. The cost sharing in year one had to be theoretical to get to

that benefit which never existed before and we, and I think everybody else who tried to do this and had their actuarial equivalence accepted said, here's our past experience from one or more data sources. Here is what we would have paid had the benefit been arrayed this way. We actually had a micro-simulation model that did that. And here is what this other benefit looks like.

So, again, highly theoretical but we've matched the cost sharing as best we could under that. This year is too early '07 because we just got three data points so far, but for '08 we'll actually have defined standard benefits -- CMS will know that -- to compare against all these others. So this experience will emerge pretty quickly.

Can I go with my other comments too at this point?

To get a possible second answer to, Bob, your and Alan's questions, I think the retiree drug benefits are a good place to look. My recollection, from I know about them -- and we're not a big player in that though -- is that the over-65 retiree formularies are, for the most part, the same as the under-65 formularies. They are a good place to start. And for the most part my recollection also is that when the whole USP was being described with 146 categories,

those were larger than the roughly 90 or somewhat fewer categories that many plans like the Blues would have. But I think that would be a good question for Jack and Cristina to look at.

Then lastly I'll add my comment to them. First of all, it think this is a very good way to look at this, Jack, very concise for all the stuff you went through. But there has been a lot of consolidation and I would suggest, after we get the membership numbers finally, that you redo just this package with the membership weighted there. Urban legend has it that one of the PDP bidders has got exactly one member and yet you're evenly weighted across everything here.

DR. HOADLEY: We would obviously love to have enrollment numbers at this point to do that.

Let me just make one comment on the comparison with the commercial. For a project we did last year for HHS we tried to look at some commercial formularies. This was it in advance of Part D stuff being available.

One of the problems is you don't really have a database available to do that. What we found ourselves doing was literally going to the Internet, finding PDF files

of formularies listed in any way that that plan chose to list, perhaps not complete. They don't always claim they put every drug on their list that they put out for the consumers or even for the providers. And then, not only having to make sure we accurately captured this verbal description of the drug and translated it to a technical description of the drug, but then worry about the completeness of the list.

So the real challenge to do that would be to get hold of some kind of a data source or get the cooperation of plans to provide us databases of their formularies so we could do some of those kinds of comparison.

MS. HANSEN: I just wanted to verify Jay's point about looking at it from the beneficiary standpoint. I think once we do the formulary and once we have the members identified, the ability to take it from on the ground as to what beneficiaries with certain kind of classic chronic diseases are having to face in terms of the choices, as well as the range of differential that the plans will offer so that it helps beneficiaries make more informed choices as well.

Then finally, the whole area of the low-income

population, that's going to be sorted out once the members were identified to be able to see where they sort out with some of the different plans would be great. Thank you.

DR. MILSTEIN: Other than prior authorization, which is a very bulky and administratively difficult tool, under Part B our plan offers, permitted to in any way limit use of medications on the formulary to the indications and conditions for which the medication was either listed in the formulary to begin with in terms of the category it fell into, or FDA approval. I'm really getting at the question of is it possible -- have any plans aspired to do this? And if not, is it related to restrictions embedded in the Part D regulations?

MS. BOCCUTI: I'll take a crack and Jack you can add in.

Whether it's off-label use or use for other things, I think that is a prescribing physician choice there. Then even being able to track it is difficult because you don't really, when you get the data, you won't be able to say what it was actually used for. In many cases when you have diagnostic information and what other drugs they're on you can make an assumption. And in some cases

you can look whether it's used for rarer reasons.

But I'm not aware of that much prescription in the drug prescribing for specific conditions. With the USP classes I think there was some thought about that, but Jack you might want to add in.

DR. HOADLEY: I think Cristina has that just right. There's no diagnosis on the prescription slip so if you're just doing this as a straight claims thing there's no way to verify that. I think that is where prior authorization enters in.

My assumption is that if a plan wants to say, we only want this drug used for this very narrow purpose, that's where you place a prior authorization restriction and you make sure that the doctor is prescribing it for that purpose before you authorize the dispensing of the drug.

DR. KANE: I just had a question around the actual equivalent issue.

If most of the non-low income people, clearly based on focus group and market work, decided they really wanted a tiered copayment and yet the low-income group is on a 25 percent coinsurance, I'm just wondering if that's really actuarially equivalent. That's what this thing says,

that the low-income groups were still mostly on the 25 percent coinsurance. Is that an error in the write-up?

MR. BERTKO: No, it's correctly stated, but you have to remember the low income folks have the cost subsidies that determine --

DR. KANE: I know it's being paid -- I understand that and that's my question, is that good for Medicare? Who's paying for it? And is it really actuarially equivalent or should Medicare as an efficient purchaser reflecting the best possible deal, should they consider that actuarially equivalent or should they go with the market and say, we really want to shop on behalf of these people in the way that the non-low income people are choosing to shop? Is it really actuarially equivalent or is it not?

MS. BOCCUTI: I can't talk about the -- I don't know the models and that's been reviewed with CMS reviewing it. But I'm not sure we can even make a judgment about what's costing Medicare more money right now. We have to see some use and see what's going on with what's on the formulary and what drugs are actually claimed in order to be able to compare whether there is a better value at one tier structure over another.

DR. HOADLEY: But certainly if the actuarial equivalence concept works the low income beneficiaries are only going to be eligible for plans that are non-enhanced plans, so are either the 25 percent standard benefit or actuarially equivalent to it with tiered cost sharing. If the actuarial equivalence model works then they're all in equivalent models.

Obviously, actuarial equivalence is not designed to be equivalent for every single person. It's across the aggregate. So for a given individual it may be different.

DR. MILLER: I could hear this question just a little bit differently because I don't know how much we're going to be commenting on actuarial equivalence. I think really the policy question I hear here is, once we have some experience and we see what's going on, are the utilization patterns in these plans different such that someone might want to think about how this subsidy is structured and which plans the low income are being put in? As opposed to, is it actuarially equivalent, which I think is a different concept and you can make things actuarially equivalent a lot of different ways.

I see the relevant question being, are these the

right plans for these people to be in, and is Medicare getting the right kind of utilization patterns out of it, whatever right means in this conversation.

MR. BERTKO: Just a quick expansion. Nancy asked an interesting question but not necessarily the right question.

Setting aside the question of actuarial equivalence to the one that I think you mean to answer is, is Medicare, with the low-income subsidy, being a good purchaser?

There's a second part to this which is, compared to what? The what, in many cases, was no copays. So now there's a dollar/$3 copay for almost all of these.

And secondly, at least one plan might have some early indications of very intelligent selection of generic usage in there. Then I guess I think everybody would agree or I would hope everybody would agree here that even a dollar and $3 per prescription for low-income individuals is in fact a decent incentive and maybe corresponds to $10 and $30 for average income seniors.

DR. MILLER: The very last thing I wanted to say is there were about three or four comments that I felt were

on one subject, and since we have to react to them I want to be sure that -- as we go forward, I want to make sure that I capture them.

So there's the one comment of, we need to be thinking about a reference point here, ESI insurance or whatever the case may be. I think that's pretty clear in my mind.

And then a couple of other people seemed to be saying, I want you to construct almost a profile of a beneficiary, or a condition, or something where you could then use that to track across plans to see how the different drugs would be treated. I felt like I heard that too.

We'll have to follow up and figure out how to actually do that.

DR. NELSON: Including the administrative burden. It would be really helpful to have an index in addition to straight class.

MR. HACKBARTH: Well done. Thank you.

Next Joan is going to make a presentation on beneficiary education and how they made their choices

DR. SOKOLOVSKY: This morning I want to talk to you about how beneficiaries learned about the drug benefit

and their particular individual choices. Some of the key questions include, did beneficiaries have the information that they needed to make informed decisions? Who helped them when they made decisions about enrolling in a drug plan? And what factors were most important to them in deciding on a specific plan?

This work allows us to evaluate what beneficiaries most valued in a drug plan and helps us think about the best ways to support their decisionmaking in the future. The material we gathered was very rich and I can just give you really a sample in this presentation. I'd be happy to provide further details on questions.

I think the key findings can be summed up like this: for beneficiaries who signed up for a drug plan or are considering signing up, the decisionmaking process has been long and for many of them rather difficult. However, the majority do believe they have enough information to make a decision.

Most beneficiaries made their own decisions about whether to sign up for a drug plan. While beneficiaries discussed their choices with family and friends, few used the Medicare help line or web site. About 25 percent of the

people who had help relied on advice and information supplied by insurance agents and drug plans. We found that many people in our focus group used the Medicare handbook to find out what plans were offered in their areas and then contacted the individual plans directly for information.

For this project we contracted with a team of researchers from NORC and Georgetown University to complete three interrelated studies. The first was a telephone survey of Medicare beneficiaries that was fielded from February 8 to March 2. The questionnaire concerned decisionmaking about the drug benefit and the sample was nationally representative.

The second study consisted of six focus groups, three held in Richmond, Virginia at the end of February, and three held in Tucson, Arizona during the third week in March. In each location we had a separate session with family members who were helping a beneficiary make a decision.

In Richmond we had one beneficiary group that was entirely composed of dual eligibles. None of the beneficiaries in Richmond were involved in a Medicare Advantage plan. But in Tucson, each group contained a

mixture of beneficiaries from MA plans and traditional Medicare.

For the third study we interviewed about 30 counselors in 14 different states. They discussed their work doing outreach to tell beneficiaries about the benefit and doing individual counseling to help beneficiaries make decisions. They also helped beneficiaries with problems they encountered during the transition in early 2006.

About 70 percent of our sample had some drug coverage before January 1. Those who had employer-sponsored insurance and intended to keep it were not asked other questions about decisionmaking since they didn't really have a decision to make. This slide is about the experiences of people who did have to make a decision and it doesn't include, therefore, again the people with employer-sponsored insurance which in this case includes VA and TriCare.

Of those beneficiaries who knew about the benefit and didn't have drug coverage from these sources the respondents in our survey were almost equally split between those who had signed up for a plan, 30 percent, those who were not considering signing up for a plan, 34 percent, and another 16 percent were still considering their options.

Let me explain that additional box here, the auto-assignment number. Just over a quarter of those in our sample who didn't have employer-sponsored insurance reported receiving a letter assigning them to a specific plan. Of them, more than half said that they were keeping the plan to which they were assigned. These are represented by the box, accepted auto-assignment. About a third of them switched, chose a different plan, and we put them amongst the people who had signed up for a benefit since they had made a decision and signed up. The others who were considering switching but hadn't yet done so were put in the considering category.

We asked beneficiaries who had signed up for the benefit or were considering signing up what reasons they thought were important for signing up for Part D. More than 90 percent said that saving money on drug costs and protecting themselves in case their drug costs went up in the future were important or very important reasons to sign up. Another 72 percent said that avoiding a penalty for late enrollment was important. That number was even higher amongst those who had not yet made a decision. Seventy-one percent thought that being able to buy drugs that they

couldn't afford before was an important reason as well.

Beneficiaries in our focus groups also said that saving money on drug costs and avoiding the penalty were important reasons. But it was very striking to us how few of them thought of drug plans as an insurance policy against future costs.

There was one incident in particular that I think captured all of our attention. There was one man in one of our focus groups who said that he was very healthy and had no drug costs but his wife was very conscientious and had done a lot of research and signed both him and her up for plans before the benefit began. Then at the very end of December he suffered a massive heart attack and suddenly he found himself taking many drugs.

And he looked around at everybody at the focus group and he said, you know, if you think about this benefit as if it was -- I don't know, almost like insurance, it really makes sense. It was striking not just to us but to the other people in the focus group, at least one of whom had said she was not considering signing up and said that she was reconsidering her decision.

The most common reason people in our survey gave

for not signing up for a plan was that they had other drug coverage. Almost half of beneficiaries listed that, in fact, as their primary reason. Remember, this was true even though the people with employer-sponsored insurance were taken of the sample. Other beneficiaries reported that they did not take many drugs or didn't think the benefit would save them money. Less than 10 percent reported that they didn't sign up because the choices were too confusing.

I should note that --

DR. REISCHAUER: Joan, can you tell us why they had coverage although they weren't part Medicaid?

DR. SOKOLOVSKY: Many of them had Medigap drug coverage. Some people who had MA drug coverage did not consider staying in MA getting Part D. They thought of this as avoiding Part D and they were included in that. Some had drug coverage from state pharmacy assistance plans. Some of them had discount cards treated it as if it was drug coverage. It was definitely something that we had to follow-up on to try to make sense of, yes.

In general beneficiaries who didn't sign up were more likely to use no drugs on a regular basis and spend less money on a monthly basis for drugs. In fact about half

of beneficiaries in our survey who were not considering signing up used two or fewer drugs on a regular basis. This was also true of beneficiaries in our focus groups and beneficiary counselors reported the same pattern.

Most beneficiaries, about two-thirds, researched and made decisions about signing up for a Part D by themselves. However, those who signed up or were considering signing up were more likely to have had help than those who were not considering signing up. Those who reported that they did get help or advice from others primarily relied on family and friends. The next most common source of help and advice were insurance agents and drug plans. Twenty-six percent of those who got help consulted these resources. Relatively few beneficiaries reported receiving help from a doctor, a pharmacist, or a counselor.

Focus group members also discussed consulting the Medicare & You handbook, although they did report that they found it confusing and, in one case, used the term legalistic. They also mentioned talking to representatives from individual plans, sometimes at events held in stores. Some used the handbook to get a list of local plans, all of

their options, and then contacted the plans directly for information, including whether there particular drugs were covered.

The beneficiaries in our focus groups reported more contact with pharmacists, but that was really the only difference we found.

About one-fifth of survey respondents said they or someone who helped them called 1-800-Medicare, and only 11 percent said they used Medicare.gov web site. The majority, about 60 percent who did use these sources, found them helpful. In general, few focus group participants described using web-based tools or counselors to help them make decisions. They were more likely, again, to describe plan descriptions that they received in the mail, phone calls to plans, and conversations with plan representatives. More family members in our focus groups noted that they used the Medicare web site, but even here this was a minority.

MR. MULLER: Where is this number on chart 7? I didn't see it in seven.

DR. SOKOLOVSKY: What I'm saying now is on chart 8.

MR. MULLER: I know, but if you go back one where

are the people who went to the web site on this one?

DR. SOKOLOVSKY: It's not on this one. In fact this one asks whether you or whoever helped you used these sources, so it should include, for example, the family and friends on the other chart, also the people who made the decisions by themselves.

MR. MULLER: Wouldn't going to the web site be a source of help? Why is that not a source of help?

DR. SOKOLOVSKY: We wanted to get at, no matter how you did it, whether you did it by yourself, whether you did it with the help of family and friends, whether you did it with the help of a counselor, did you use this source. We wanted to get the broadest possible number here.

MR. MULLER: I'll come back later.

DR. SOKOLOVSKY: On the other hand, most SHIP counselors got their information from CMS and used the web site to help them narrow down all beneficiary choices. At least 90 percent of beneficiaries in our survey thought financial considerations like how much the plans charge for copays and premiums, whether their particular drugs were covered, and how much money they would save overall were important when deciding on a specific plan. The reputation

of the company offering the plan was also considered important by 90 percent of our survey.

In our focus groups this factor was also considered important with beneficiaries saying that they were wary of unfamiliar companies because they didn't know if they'd still be there in the following year.

Using their customary pharmacy was important to 84 percent of beneficiaries with a somewhat higher number of beneficiaries in rural areas reporting that this was important.

Fewer than half thought it was important to sign up with the same company that their spouse used, but yet 42 percent of beneficiaries did think that this was important.

Beneficiaries in our focus groups also thought cost and coverage of their drugs were the most important factors. Some beneficiaries found customer service a determining factor. For example, one man called all of his plan options and eliminated any plan that would not give him, promptly and clearly, answers to his questions. Many reported difficulty getting service lines to tell them whether their specific medications were covered. They were often told by the customer service line that they only gave

that information to people who were enrolled in the plans.

[Laughter.]

DR. SOKOLOVSKY: Individual counseling for beneficiaries has been conducted through state SHIPs and other volunteer grass-roots organizations. SHIPs are state-based organizations that receive federal funds to counsel Medicare beneficiaries about insurance issues. The MMA increased funding for these groups from about $12.5 million in 2003 to $32.7 million in 2005. For 2006 that funding has been reduced by about $1 million. The SHIPs provide individual counseling to beneficiaries as well as organizing informational events.

Although only a small percentage of beneficiaries reported having used the SHIP services, when you look at actual numbers it translates into 4.2 million beneficiaries in the past year receiving individual counseling from SHIP counselors.

Counselors report that they were in fact overwhelmed by the volume of calls that they received. For example, one office reported that calls increased from 3,000 a month before October 2005 to over 30,000 a month in November and December.

We generally heard that SHIPs are counseling more of the disabled beneficiaries and dually eligible beneficiaries than they ever had before but were still having trouble reaching the population that was likely to be eligible for the low-income subsidy. Some groups provide help in languages other than English, and some groups representing people with particular disabilities or medical conditions also provide counseling to their members.

We were told from the SHIPs that beneficiaries are confused by the number of plans, the variation in benefit structure, and the penalty for late enrollment. We heard these same thoughts expressed in our focus groups.

While the majority of the beneficiaries in our survey thought they had enough information to make a decision, more than half of the beneficiaries who signed up or are considering signing up have found the decision rather difficult. Beneficiaries who have signed up are more likely to think that they had too much information, while those who were still considering the decision were more likely to report that they had too little.

Beneficiaries have found the decisionmaking process very time consuming. Half of the beneficiaries who

signed up for a plan said it took them eight hours or more to come to a decision. Forty-four percent of those who were still considering their options have reported that they have already spent eight hours or more on the decision.

In our focus groups, beneficiaries complained about the lack of comparability in the information that they received from plans. Several spoke of wanting a document that compares plans in an apples to apples way. Others suggested a comparison chart or a simple checklist that clearly shows the prices and coverage policies of each plan or provides answers to frequently asked questions. Some suggested that Medicare should standardize the benefit packages that plans could offer so that then the beneficiary could compare more clearly their choices.

Counselors, on the other hand, were more likely to emphasize that plans' offering should be limited because beneficiaries were confused by the large number of choices.

Again I can really only skim over some very rich material and await your comments and whether there are other areas you would like to see more information on.

MS. BURKE: Joan, first a question that probably seems a little odd but just, to what extent can we determine

the gender of the person who gave counseling on plan choice?

DR. SOKOLOVSKY: The SHIP counselors?

MS. BURKE: Not just the SHIP counselors. There has been traditionally a view that women tend to be the primary decisionmakers, certainly under age 65, in making plan choices or in making insurance choices for their families. Obviously, the gender of those over the age of 65 is predominantly, if you were to look at it, female anyway.

But it would be interesting to understand and to know whether or not that pattern has continued here. As a look at family members and you look at others, has it predominantly been women in the family who have provided this information? But it's an interesting question only to the extent that as you think about how you market the information, where you market the information, whether there's any kind of gender bias -- I don't mean that in a pejorative way -- that might assist us in understanding how this information is provided, and by whom, and in what settings. So that the further detail we get on that chart that you provided on where they got it and from whom might be helpful to us going forward.

The other question I think is a more fundamental

one, Glenn, in terms of this chapter as well as the chapter before. And it may well be something we want to think about in the context of our retreat this summer, and that is, at the end of the day what is it that we think we ought to be tracking? What are the questions that we really need to fully understand as we go forward with the implementation of this benefit?

Certainly in this chapter the whole question of how one navigates through very complicated information, how we distribute the information, the source as well as the complexity of it, all those kinds of questions that are more broadly applicable to Medicare, and to the extent that we move in this direction in terms of choices going forward, would be very helpful.

But I think for the Commission's standpoint pausing and thinking, as this thing is implemented what are really the things that we want to understand, prices, choices, design features, all those kinds of questions. But it would be nice to get a handle on and a structure as we go forward, what are the things we want the staff to begin to routinely report back to us on? What are the indications that will be helpful to us and to what end? What is the

question we're asking, other than the obvious one, is the benefit worth it? Are we paying the right thing? Are the people getting the right services?

But it would be good to get a sense of that in both of these chapters and in this broad benefit. What is it we want to learn and what is it that we should be understanding and asking the staff to track as we go forward? Because there are about 87 different moving pieces here and to get some sense of that might be helpful for us.

MR. HACKBARTH: In one of our previous reports, and remind me which one it was, we began the process of laying out what sort of ongoing measures of performance we might want to track in general about Part D. When was that?

DR. SOKOLOVSKY: Last June.

DR. MILLER: June '05. That's right where I was going to go and say, for the summer of session when we start laying out plans for the cycle that starts in September, first step would be to bring that back up and get that back in front of you. I think even from Joan's work and Cristina and Jack prior to this, we've begun to get a little richer understanding on a couple other of these elements and we can try -- some of the reference points that you were talking

about -- bring that in, put it all in front of you again and ask ourselves, is this how we're going to be tracking this benefit.

MS. BURKE: The other thing that I have raised at previous meetings and I continue to be concerned about -- and it may well just be that I'm not informed currently about what's going on -- and that is the mining of the data that will be produced from the benefit, and how we are going to use that information, and how CMS is structuring that question. How quickly will we begin to see patterns? How quickly will we begin to be able to look at how different physicians behave in fact of their prescribing patterns and best practices?

I remain somewhat concerned that that hasn't yet been fully thought through, and I know that the coordination with the FDA and with others, while everyone says that's going to happen, I'm not yet even certain that that is happening to the degree we might ultimately want to have it happen for a variety of purposes, both for the FDA's purposes in terms of watching what happens in terms of medications, but also for our own purposes in terms of best practices. So particular attention to that issue, which is

what is happening with the production of data, how quickly we'll be able to look at the data.

I don't want to get back into the pattern we're in currently where we're looking at cost data that's four years old or five years old. Are we planning at the outset of this new benefit to really begin to understand that and gather that information? I'd feel better if we had a better sense of that as well.

MR. HACKBARTH: At this point again there's a very basic issue about what data we will get and when we will get it, which is an ongoing matter of some interest, shall we say.

Dave actually participated in some of this research as I recall.

MR. SMITH: I attended the focus groups, so I didn't participate as much as I observed.

MR. HACKBARTH: Watched it, shall we say.

MR. SMITH: Joan did a terrific job. Just a few observations.

The survey was fielded and the focus groups were help before some critical benchmarks, the 90-day benchmark being the most important one, and the run-up to May 15. So

both of those things are likely -- we don't know whether the population that was energized and signed up and paid attention, or energized and paid attention and didn't sign up, we don't know if they're different than the group of people who will be signing up now. So this is useful partway information but there's a lot more to know.

A couple of thoughts, and again this is just from the focus groups and Joan has mentioned most of it. A lot of anger. Too confusing, too hard, mad at plan representatives who couldn't answer questions, mad at Medicare for having created such a complex and unwieldy thing. And a surprising amount of satisfaction. Anger was there, but people who managed to negotiate it or had somebody to negotiate it for them, or were auto-enrolled, to the extent that they had experience with filling a prescription, accessing the system, were quite satisfied.

The third part of that observation, an awful lot of suspicion that something bad is going to happen. The plan is going to go away, prices are going to go up, they're going to change their formularies so my drug isn't on it. That set of suspicions were partly born by how complicated it is. It wouldn't be so complicated if they weren't trying

to mess with me. So the worst is yet to come was the answer even among those, or was the view even among those who were relatively satisfied with what happened so far.

Three last thoughts. Helpers weren't very helpful. Helpers, whether or not they were kids or neighbors or counselors didn't provide very good help. One of the focus groups in Richmond was helpers. It was probably the least informed, least articulate group of any of the folks that we met with.

The most successful people it seemed to us, I think we all agreed, were the young, computer-friendly recent retirees. So they had time, which was important, and they could use the technology in ways that most of the helpers found difficult and the older elderly found difficult.

Joan said this but I really would emphasize it, virtually everybody who either enrolled or not who expressed a view about what was most important, put my drugs before any of the -- I want to make sure I can get my stuff, and everything else fell behind that. But people started with, I'm on, and to the extent that I've got a first sort, that's what it is.

MR. MULLER: As these chapters note, this is the first benefit that really isn't offered in the regular fee-for-service system so I want to comment a little bit about what we might learn about that. One, just following up on David's point insofar as the beneficiaries make this choice once a year, though the formularies perhaps can change, it forces people to make a choice. And if they're making their choice primarily on the drug "my drug" it would be interesting to see how satisfied they are with that. Maybe one of the reactions is that it can't just have a dynamic change of formulary at the same time we have a static choice of plans.

It's also interesting, if you look at some of the evidence of choice in 401(k) plans where there's a considerable difference by income as to whether people make any contributions beyond the kind of, to use the phraseology of Part D, the auto-enrollment, basically the basic contribution that the employer makes. And by and large you find there of the lower income populations in 401(k) plans barely 10 percent of them do anything beyond the auto-enrollment, to use that metaphor, and the higher income participants make more contributions, in the sense that it's

obvious based on income.

But it would be interesting to see inside of this whether we start seeing different behaviors in terms of plan choice as it evolves where the more higher income beneficiaries making and being more dynamic in terms of their choices that they do make over time, being more responsive to their changing medical needs. Obviously in the fee-for-service system, in a sense one can make a choice as your health needs of all because basically by having access to a physician you can change your -- in a sense, if you had on other services aside from pharmaceutical benefits you obviously have a choice on your doctor can decide what kind of services you need. Here you have more of a static choice.

So I'd be interested in seeing, in terms of what we follow over a period of time, some of these demographic variables if in fact they evolve. Are there big differences between the more higher income rather than the lower income beneficiaries within the plans? What kind of changes are made as people's health needs change? Understanding some difficulties exactly in tracking those health needs.

I also want to also then, in addition to those

comments, come back to the point I was making earlier. Since a big part of the effort by CMS was in fact to have the web site and the 800 number available I wasn't able to follow off the charts how important that was in terms of people making choices. The obvious point, most people on most big decisions in life, go to their friends and family first, so I understand that.

But how important was the web site and the 800 number in terms of helping people to make choices? That goes back to my question about how page 7 and page 8 interrelate.

DR. SOKOLOVSKY: Again, two-thirds of our beneficiaries said they made the decision by themselves and 49 percent of the people that were left said they went to family and friends. We asked, did you yourself or whoever was helping you, call 1-800-Medicare or use of Medicare web site. About one-fifth made the phone call, called the Medicare help line. But only 11 percent, counting themselves and their family and friends -- although it's possible they don't necessarily know all that their family and friends did -- used the web site.

MR. MULLER: So that's 11 percent of the total

population used that?

DR. SOKOLOVSKY: That were making a decision.

MR. MULLER: Did anybody have any a priories on -- I would have thought many more people would use it given the complexity of the choice. I would assume that might be -- I know the President said people should rely on their families and friends but that strikes me as a low number. I didn't know if there were any estimates in advance as to how many people go to it. I tried it myself just to -- and in fact I thought it was quite, like many people, it was quite helpful. But again being reasonably used to computers it probably would be more helpful to people who do this all the time.

DR. SOKOLOVSKY: One thing that was interesting was that there were people who did a lot of research but they did research in the way that they were accustomed to doing research all their life before computers, which was I went to the book, I found out what plans were offered, then I got in touch with every plan -- in some cases that was a lot -- that was offering and asked them to send me all their materials so I could look at them and make a choice. Or it could call them and ask them about my particular drugs.

MR. HACKBARTH: Is it a concern that people will look at numbers like that, those low percentages, and say these are tools that weren't widely used, therefore we ought not invest in them? You can imagine, like the web site, that in subsequent iterations of this process that over time it might build up --

MR. MULLER: Age into it.

MR. HACKBARTH: In part because of the aging-in of the population, people more comfortable with computers aging in, but just word of mouth, people saying, this really worked good for --

MR. MULLER: Because e-mail use is quite high among the young elderly, way above 11 percent.

DR. MILLER: Joan, I also think you hit this point in your presentation but just to reinforce it, the counselors who were counseling the beneficiaries do depend very heavily on the web site.

Let me just ask one more time on this number, the low usage. So we were able through either the survey -- I guess the survey in this instance, to determine that if somebody helped the beneficiary whether they had used the web site?

DR. SOKOLOVSKY: That's what the question asked. To course with all surveys you don't know exactly what people are answering compared to the question, but that is what the question asked, not just you but also the family or whoever helped you.

DR. MILLER: So the question was to the beneficiary, did someone help you, and did that person use the web site, was a sort of the question. We weren't asking the helper directly if they had used the web site?

DR. SOKOLOVSKY: That's right.

DR. MILLER: This is what I thought, because we had some of this conversation when we were just getting our heads around it. So that number that we just arrived at there, remember that's through the beneficiary. Somebody helped me. Did they use the web site? Then you're getting that second recall there. So I would just give you some caution on that number.

And then not to put you on the spot but the other way to inform this question is, when you were doing the focus groups, in there, either from the elderly or from the beneficiaries or from the helpers what was your sense of the use of the web sites in that setting?

DR. SOKOLOVSKY: It was still definitely a minority. The ones who were more likely to do it were the younger elderly, and in some cases the family members. But the family members complained they didn't have the time to do it.

DR. CROSSON: A question for Joan. Earlier on in the presentation, when you were talking about the categorization of people I got a little confused as to where the MA-PD people were. So on slide four, were they in the have signed up, the auto-enrollment category, or were they in the already had drug coverage category on slide six?

DR. SOKOLOVSKY: I think you've put your finger on one of the most puzzling aspects of the survey. If they said they got an auto-enrollment letter and it was from their MA-PD and they kept it, they were in the accepted auto-assignment. Some people clearly didn't understand the question and instead treated it as an alternative source of drug coverage. We saw that in the focus groups. In Tucson there were many people who were in MA plans and said, I didn't have to worry about Part D, I have drug coverage through my health plan. I really like it. I'm sticking with it, and it's even better this year than it was before,

with absolutely no concept that this was an MA-PD; it was just their MA plan. So I think that those people are scattered into different boxes.

MS. HANSEN: Two questions. I think we've been talking about some observations made/lessons learned and thinking that people will probably have another iteration of choice when the market starts to change. Are there some summary areas that we could identify as to how to do it differently and more effectively next time? That's one question.

The second question is, given the challenge of outreach in terms of -- which perhaps is an earlier presentation to the low income population that's still hard to find, and noted by the SHIP counselors, are there best practices that have been able to be identified as to groups that have been more effective in reaching this tough to access population?

DR. SOKOLOVSKY: I think that's an area where we need to do more work. It's clear that there has been a -- all the counselors say that they're having a problem reaching them. I suspect we could find some sources that have been more helpful.

I can tell you that in our survey 10 percent of the survey said they applied for the low income subsidy, but of those only a third received it. So I think there is also that kind of issue.

DR. MILLER: To the first part of your question, some of my reaction in listening to this is the concept of communicating that we're talking about an insurance benefit here, and again what that means in marketing strategy and how one translates that I have no idea. But the notion that that doesn't seem to be breaking through.

And then secondly, if it is in fact that people are going to be going to the plan materials in their area, what attention is paid to be sure that those materials are readable, as comparable as possible from plan to plan, so that people can understand what they're looking at from plan to plan, are at least two things that struck me when I was listening to Joan.

MR. HACKBARTH: I agree with both of those points. I've looked at this step in the process as primarily trying to understand what's happening, as opposed to formulate very concrete recommendations. We can and should do that at a later point. But where this falls in our cycle and relative

to the report I think first and foremost this is information for us and for others to chew on on what's been happening real-time.

DR. REISCHAUER: I'm going to offer a couple of radical observations here. I think the big danger is that we spend too much time focusing on this issue and analyzing it, slicing it and dicing it. As several of you have said, this isn't the most consequential or irreversible decision in the world. People are going to have an opportunity once a year to change, number one.

Number two, the consequences of making a bad decision, meaning choosing plan B rather than plan A, are not huge here. They might be a few bucks here or there, and there is an element that ex ante one never knows what ex post is going to be the "right" plan given your drug needs over the course of the next 12 months, which you don't really know what they are. The wrong decision or bad decision is not to sign up at all, and that is clearly a wrong decision for somebody who has a heart attack the next month. But maybe not the most consequential wrong decision if you end up not having a catastrophic drug-dependent problem before the next sign up period. Then you're just

subject to the extra payment over the rest of your lifetime.

To take the very extreme example, you're somebody in Iowa who has as an opportunity a $2.50 a month premium and I wait three years before I sign up and so I'm subject to 12 percent a year. Rather than $2.50 I'm going to have to spend $3.50 for the rest of my life on premiums. That's not the biggest hit in the world. So even the consequences of "wrong" decisions aren't --

We study and analyze what is a once in the history of this program situation, which is signing up a lot of people who are in other coverage or didn't have coverage and range in age from 65 to 100 and X. But three years from now that's not going to be the issue. It's going to be new 65-year-olds coming in and signing up who are going to do it in a very, very different way as part of the signing up for Medicare to begin with. And they're going to be in an environment which has a lot of experience out there, a lot of different kind of information that isn't available now, probably a much reduced set of alternatives because the number of offerings is undoubtedly going to shrink. They're going to have different capacities because they're going to be the young-old who are much more computer savvy, et

cetera.

So whatever we can learn from this process now might be very informative for political frustration and reaction in the next couple of elections but I don't think it's going to tell us a whole lot about how to design information systems and mechanisms for the decision process that we're going to face over the long run.

MR. DURENBERGER: I've been doing a lot of public television back in the fall and then again quite recently and I just want to go on record thanking Sarah and Joan and the staff you started this process for doing it because it was incredibly helpful to us in designing this last one, which is going to run twice a week between now and May 15th in the Twin Cities market and in some of the other related markets. Particularly the story about insurance, because it was very, very helpful to know how people have been making decisions. I agree with Bob about the fact, the emphasis has always been you can't get hurt making a decision. Make one. But some of you are going to make it for this reason, some of you make it for that reason, but understand the insurance.

Anyway, I'm really grateful to the staff for the

work and for taking the time to be helpful

My second comment, for some reason or other I often think like a legislator, but when I think in terms of the potential for near-term legislative changes two of the things that occur to me, one of them is, that I think I recall from Joan's information, a lot of people made a decision simply because of fear of the penalty. So one of the questions that will occur to people over time is, why the penalty? It's obviously a fundraiser. And the first time around it might have a lot of weight, but is that an appropriate mechanism for decisionmaking?

I don't know the answer to that but I'd love to know it.

The second one she raised also is the issue of comparability. I think we have all found over time, yes, obviously it's hard to do the first time around, maybe the second time around, but the changes that made consumer choice in the Federal Employee Health Benefit Plan work probably the best is, the more comparable you could make the plans, the benefits within the plan, the prices for those benefits and so forth, the easier it made the employee's choices. So I'd have a fairly strong interest in any

recommendations we might come up and the analysis that goes with it that would aim us in the direction of comparability of plans, benefits, and so forth in the future.

MR. BERTKO: I'd just like to respond to at least a part of Dave's second comment here in the penalty. Number one, there's comparability to Part B which has the penalty. It's same size of penalty percentage-wise in voluntary versus involuntary.

Number two, in the bidding for this, having a penalty there influences the risk mix. So using Joan's example there of the guy who was glad he had signed up because he then had an incident, the selection dynamics of who chooses, were they to be able to come in the month after they have a massive event is different than if you have a penalty in which they say, once a year I should think about signing up on this date, so that you have a more even mix of folks there.

If you change that, you then change the bids, you then change the cost to the Treasury. There's a whole set of dominoes that fall were you to make those changes.

MR. HACKBARTH: The logic of the penalties still seems sound to me for all those reasons, although Bob's

example about Iowa and the magnitude of the penalty being linked to the choice you make and the variation in premiums, on reflection does seem odd to me. To achieve the results that you're shooting for, you'd want it linked more to the underlying total cost of the program as opposed to the beneficiary's share.

MR. BERTKO: Let me answer that. The words in the statute actually are to be linked to that. But the default is, use 1 percent until you know what the actual cost is. And it's 1 percent of the average premium. So it's 1 percent per month of $32.20 a year for this year and then whatever it emerges in future years.

DR. MILLER: That was key to get out in this discussion because the penalty is linked to the average cost of the contracts.

MR. HACKBARTH: But it's still to a share of the cost as opposed to the total program cost including --

DR. MILLER: The beneficiary's share; that's right.

DR. MILSTEIN: I found the qualitative information on beneficiary success in decisionmaking extremely helpful. I think it would be even more helpful if we could find a way

to more routinely populate, I'll refer to it as our MedPAC dashboard, with quantitative information on the topic of quality of beneficiary decisionmaking, not just in relation to drug plans but in relation to all the important decisions that is implicit in Medicare enrollment, choice of doctor, choice of hospital, et cetera. I think it is especially important, obviously for a population that has the burden of increasing cognitive impairment.

The good news is I think there's been some pretty good social science progress, especially over the last 10 years, in quantified measures of decisionmaking quality. I'm thinking about research on simply whether or not people had the correct understanding of the information done by Judy Hibbard. Some of her early work, for example, showed us that not just Medicare but any American beneficiaries shown HEDIS scores, to a very high percentage, were incorrect in what they believed was the favorable direction of the score. Often a low score was desirable. They thought and the cognitive testing showed that the beneficiaries thought that the high score was better. It's that kind of fundamental chaos in cognitive grasp.

And then secondly, and more recently folks like Al

Mulley have done some really nice -- assuming people do understand the fundamental facts, have done some very nice work on how we go about quantifying beneficiaries' concordance of choice with their intended preferences. So those are two needles that over time it would be, I think, very helpful for all us to begin to have on our dashboard, irrespective of the category of beneficiary decision that we're looking at. I think the qualitative evidence we've seen suggests a big opportunity to improve Medicare decision support and the value to us, if we could have a quantified measure that would allow us to build our recommendations around.

In retrospect, I helped three family members with their decisionmaking. I have to tell you, at the end I did not feel confident about the advice I gave and I'm only mildly cognitively impaired.

[Laughter.]

DR. SCANLON: Let me just disagree a little bit with some of Bob's heresy. I subscribed to most of it, but the idea that there is no bad decision at this point I think is something that we need to -- I want to take issue with.

For some individuals I think there can be a bad

decision and it's not one that we necessarily could have prevented. Part of the problem we have now is that there isn't enough information about plans. We've got some information about formularies and if you go the web site you can get some information about the formulary and the cost sharing. You can't get good information about the prior authorization. You can't get good information about the step therapy requirements and how they're going to work out in practice.

For people with chronic illnesses on a lot of medications, it may make a difference if they come into a plan and they do end up in a process of changing prescriptions and feeling that they have no choice but to go with the plan because this is what they can afford through their cost sharing. It's important for this next year and for the subsequent years to get more information about how plans are really working out there so people can make informed choices.

The other scary thing I think about what Joan has presented is I wouldn't say that the choices that have been made have necessarily been informed choices. It appears that a lot of people went on with very fragmentary

information. Going to your family and friends and asking them, should I buy a Ford or a Chevy may be a fine thing to do because they've got experience with Fords and Chevys. This is a new set of products that are out there. No one had experience with it. And where were they getting the information that they were using for advice?

Arnie, I would think would be responsible, he went and probably got information before he gave advice. But that's not necessarily the case for the large majority of the people that Joan has referenced as the source of information.

I think that we really need to think of what the short-term steps are we need to take to improve the information. Then we can use Bob's strategy for the longer run when we have a much smaller group and a much more informed -- and a very different market because we're going to have a very different set of plans out there that are going to be competing at some point in the future.

MR. HACKBARTH: Okay, thank you, Joan. Well done as always.

We'll have a brief public comment period.

Just the right length. We will reconvene at 1:30.

[Whereupon, at 12:28 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:36 p.m.]

MR. HACKBARTH: First up this afternoon is an update on the specialty hospital analysis.

DR. STENSLAND: Good afternoon. Today we will be revisiting several issues regarding specialty hospitals.

In a 2005 report on physician-owned specialty hospitals, we addressed the question shown above. However, we cautioned that our results were based on a small sample of relatively new physician-owned hospitals. During Glenn and Mark's testimony to Congress on specialty hospitals, they discussed the possibility of revisiting these very questions when we have a larger set of observations.

In addition, leaders of the Senate Finance Committee have specifically requested that we revisit some of these questions.

Today we will update the answers to the question shown above using more recent data and an expanded set of hospitals. In general, our findings are similar to our prior findings, the difference being that the expanded set of data, covering two additional years of experience, allows us to have more confidence in the statistical significance of our findings.

As this slide shows, the number of physician-owned specialty hospitals roughly doubled from 2002 to 2004. The proportion of physician-owned hospitals that specialize in cardiac care remained fairly constant.

As you may notice, we combined the orthopedic and surgical categories in this year's analysis. We do this because these hospitals often provide both orthopedic and general surgery services.

As this slide shows, the new specialty hospitals, shown there in pink, have tended to locate in many of the same states where specialty hospitals have located in the past. These were primarily states without certificate of need laws. The one state that didn't have specialty hospitals before that has gained some is Louisiana.

Physician-owned heart hospitals are often roughly 50 beds. While some have struggled to obtain patients, most have an occupancy level that is above 60 percent.

Heart hospitals tend to focus on inpatient services and Medicare usually represents a majority of their patients. While some heart hospitals lose money and others are highly profitable, the median heart hospital tends to be slightly more profitable than the median community hospital.

As we explained last year, part of this is due to providing services that are favorably paid under our current payment system.

However, heart hospital profitability also depends on having a significant number of profitable private payer patients.

Orthopedic and surgical hospitals are smaller and have lower occupancy. Despite the low occupancy, most are highly profitable and generate a high rate of return on invested capital. By having a strong outpatient business, serving relatively less severe cases, and having a favorable mix of payers, most of these hospitals have been able to remain highly profitable despite lacking inpatient economies of scale.

Physician investors have told us they benefit from working in a specialty hospital with operating rooms that turnover at a predictable and rapid pace. Physicians can decrease the average amount of time they spend in the hospital per surgery. This allows them to either do more surgeries or to get home earlier to their families.

Operating rooms can turnover on a rapid schedule due to at least two reasons. First, they do not face

disruption from emergency cases. Second, they rarely face delays from operating on severely ill patients with complications.

Due to the practice style benefits and financial benefits of investing in these hospitals, physicians continue to have a strong incentive to invest in this type of facility.

Julian will now compare the relative costliness of physician-owned specialty hospitals with competing community hospitals.

MR. PETTENGILL: As Jeff mentioned, one of the issues that we wanted to revisit was the question of whether physician-owned specialty hospitals have lower cost than other hospitals.

As you recall, in our earlier analysis of 2002 data, we found that physician-owned heart, orthopedic and surgical hospitals all had somewhat higher costs than their competitors and their peers. But none of the differences were statistically significant.

The 2002 length of stay data, however, showed that all three specialty hospital groups had shorter than expected lengths of stay. These results puzzled everyone

because everyone concluded well, if they have shorter stays why don't they have lower costs?

This time we're looking at cost data from the year 2004 and we're using the expanded set of specialty hospitals. Again, we're also examining length of stay using claims data from the 2004 MedPAR file. As Jeff mentioned earlier, we combined the orthopedic and surgical hospitals into a single specialty group.

Overall our findings based on the 2004 data are very similar to the findings from 2002.

The next slide is just to remind you of the main features of our methods and then we'll get to the specific results. We standardized hospitals cost to control for factors such as case-mix and input prices that affect costs but are not related to efficiency. In the length of stay comparisons, we controlled for hospitals' case-mix and we also controlled for the regional pattern of length of stay in their location.

We compared standardized costs per case in length of stay in physician-owned hospitals, specialty hospitals, against their peers, competitors and all other community hospitals. As you may recall, the peer hospitals have a

high concentration in the same clinical specialty but they are not physician-owned and they are typically not located in the same market as the specialty hospitals. The competitor hospitals offer some of the same services as the specialty hospitals and they are located in the same market. All other community hospitals includes all other non-specialized community hospitals nationwide.

The next slide shows the mean and median standardized inpatient costs per case for these comparison groups. Standardized costs here are expressed as a percentage that is relative to the national amounts for all non-specialized community hospitals. In the middle column, for example, we see that the mean standardize costs per case are about 8 percent higher in physician-owned heart hospitals than in either the relevant peer or competitor hospitals.

The median in the right hand column, however, is just about the same, at 101, as those for the peers and the competitors. None of the differences here among heart comparison hospitals are statistically significant.

In contrast, the mean and median standardized costs for orthopedic and surgical hospitals are 31 percent

and 20 percent higher than the national amounts. The costs in these hospitals are significantly higher than their competitors.

The specialty hospitals' costs are also higher than the peers but the difference is not quite significant.

We conclude that heart specialty hospitals' inpatient costs are similar to those in other hospitals but orthopedic and surgical specialty hospitals clearly have higher inpatient costs than their competitors.

The length of stay data for 2004 tell essentially the same story that we saw in 2002. The middle column in this table shows the ratio of actual to expected length of stay, the expected length of stay accounts for the hospitals mix of cases, and the regional average length of stay in each APR-DRG and severity class.

Here both types of physician-owned specialty hospitals have shorter than expected lengths of stay and the differences are statistically significant when compared with the peers and the competitors. So again they have shorter lengths of stay but, at least in the case of orthopedic and surgical hospitals, they have higher costs.

As the next slide shows, two factors may account

for these apparently contradictory findings. Some owners of specialty hospitals suggested that their costs might be higher because they have higher capital costs. This would make sense because new plant and equipment would generate higher depreciation and lease costs than older assets found in competing hospitals. Excluding interest expenses capital costs are about four percentage points higher in the specialty hospitals as a share of operating expenses than they are in other hospitals. So higher capital cost might be part of the story.

But probably the most important factor here, particularly for the orthopedic and surgical specialty hospitals, appears to be that they operate with low inpatient volume, and they have chronically underused capacity. 60 percent of the physician-owned orthopedic and surgical specialty hospitals have fewer than 20 beds and more than 70 percent of them have occupancy rates under 35 percent. It's hard to achieve low inpatient costs per unit went nearly two-thirds of your capacity is empty.

The next slide, and last slide in this section, shows this graphically. As you can see on the left-hand side of the chart, almost half of the specialty orthopedic

and surgical hospitals, who are in yellow, have under 500 discharges per year. Many of them also have low occupancy rates which tends to raise their costs even higher than they would be otherwise. But this is a price that they seem to be willing to accept on the inpatient side while they carry out the bulk of their business performing outpatient procedures.

Now Jeff will come back to the new findings on specialty hospitals' Medicaid shares.

DR. STENSLAND: An additional issue from our specialty hospital report last year was the payer mix of physician-owned hospitals. The median community hospital reported that 13 percent of their discharges were Medicaid patients in 2004. We would expect specialty hospitals to have a lower share of Medicaid patients due to not offering specific types of services such as obstetrics. However, when we compare physician-owned specialty hospitals to peer hospitals that have a similar level of specialization, we find that the median physician-owned hospital still has a slightly lower Medicaid share. Our findings are similar to research by the GAO.

The lower Medicaid share suggests that other

specialty hospital characteristics, such as location, mission, insurance contracts or physician financial incentives, may contribute to physician-owned hospitals having a slightly lower median Medicare share than their peer hospitals.

We also examined the question of utilization last year. Historically, when physicians have invested in imaging centers or diagnostic labs, the physicians' investment was then often followed by an increase in utilization of the lab or imaging services. However, it's not clear that physician investment in heart hospitals would induce more invasive procedures such as cardiac surgery.

First, we test whether utilization increases when a physician-owned heart hospital enters a market. Second, we evaluate whether physicians are following their financial incentives to shift surgical volumes toward the more profitable surgeries such as CABG surgery or surgery on less severely ill patients. We use the ratio of low severity surgeries to high severity surgeries in any market as an indicator of whether cardiologists and surgeon investors are changing the mix of cardiac surgeries when they become investors in a heart hospital.

We examined utilization from 1996, a year prior to the opening of heart hospitals, to 2004. From 1996 to 2004 the rate of cardiac surgeries per capita increased by 5.2 surgeries per 1,000 beneficiaries in markets without physician-owned hospitals and by 7.8 surgeries per 1,000 beneficiaries in markets with physician-owned hospitals. That difference is statistically significant.

Our multivariate analysis suggests that the overall rate of cardiac surgeries increased by roughly 6 percent following the entrance of a typically sized heart hospital.

Our regression model also estimated the impact on specific types of surgeries. An increase in heart hospitals' market share is associated with a statistically significant increase in CABG surgeries. The increases in angioplasties and defibrillator implantation are not statistically significant. Interestingly, the ratio of more profitable low severity surgeries to less profitable high severity surgeries did not increase significantly faster in markets with physician-owned heart hospitals. We found that the entrance of physician-owned heart hospitals may increase both the rate of highly profitable surgeries and the rate of

less profitable surgeries. Therefore, the increase in cardiac surgeries associated with physician-owned hospitals may be purely due to the increased surgical capacity associated with building a new heart hospital.

If the physicians' financial incentives are causing a shift toward more profitable surgeries, the magnitude of that shift is too small to be detected with our tests of statistical significance.

To sum up here, heart hospitals do appear to cause an increase in utilization. The increase may be purely due to surgical capacity in the market, though we can't rule out the possibility that financial incentives are having some effect.

The increased utilization only accounts for roughly 6 percent of the median heart hospitals' 26 percent market share. Therefore, the heart hospitals appear to obtain roughly four-fifths of their patients by capturing market share from community hospitals.

A logical next question is how does this affect the community hospital?

We examined profit margins, revenue and patient flows at community hospitals given those same years, from

1997 through 2004, and we found that heart hospitals do divert patients from community hospitals, causing a decline in the community hospitals' Medicare revenue. However, representatives of community hospitals have told us they have been able to expand other sources of revenue to compensate for much of the revenue loss to specialty hospitals.

The net result has been no statistically significant impact on the hospitals' total revenue or total margins. The median community hospital competing with heart hospitals had a total margin that was in line with the national average.

You may ask why community hospitals in markets with physician-owned hospitals tend to have fairly healthy profit margins. Or data indicates that physicians tend to invest in hospitals that locate in growing markets. A regression analysis found that population growth has had a significantly positive effect on hospital profit margins but the competition from physician-owned specialty hospitals has not.

We also tested for the impact of the much smaller orthopedic and surgical hospitals on community hospitals.

In that case we found no statistically significant effect on community hospitals' revenue or profit margins.

We'd now like to hear your comments and answer any questions you have.

DR. KANE: A couple of questions both on the total revenue and total margins, did you include investment income or did you try to pull that out so just closer to operating results?

DR. STENSLAND: I left that in there basically because I don't have that much great confidence in them distinguishing between operating and total on the cost reports.

DR. KANE: So it's hard to tell whether there was just better returns in the stock market.

DR. STENSLAND: I think because we did it across the nation we're comparing different parts and to see how fast did you grow from 1996 to 2004. Unless there was something unique about markets that had physician-owned specialty hospitals and somehow they were invested in better stocks than hospitals in other parts of the country, we should be okay.

DR. KANE: I think the other question, and I think

it raises a theme that I keep bringing up and maybe it's not MedPAC's concern but maybe we should talk about it, is the issue of affordability of all of these different things that happen. For instance, if Medicare allows specialty hospitals to pull revenues out of community hospitals and community hospitals find ways to make up for that, that could be one way to make up for that is to raise the charges to the private payer and do something that makes it less affordable on the non-Medicare side.

So the other question is a little bit broader and probably not even directed at you, which is should we be thinking about those kinds of costs or potential cost shifts when we're thinking about Medicare policy? That's maybe a broader discussion.

DR. STENSLAND: I'll give you a just a small tidbit from our less discussion on our site visits. There were a few people that we asked how did you overcome the loss of revenue. In a couple of cases their answer was we had some aggressive price negotiations with the insurers.

MR. HACKBARTH: But as I recall that report, there were a variety of reasons. In some cases they cut costs. In other cases they developed new services that were

profitable. There were just a variety of reasons and methods. Is that right?

DR. STENSLAND: They said those two things. Somebody said specifically we took a hard look at our FTEs, meaning they were looking at cutting costs. Some other people said we started up other activities such as pain management clinics and that kind of thing. So there was a broad range.

MR. MULLER: Thank you. This is helpful.

It's kind of a bizarre public policy outcome that we have occupancy of less than 35 percent on 70 percent of the facilities and yet we have high margins. I think normally, as one thinks to try and use expensive assets quite well and one has occupancy rates of 60 or 70 or 80 or 90 percent. And yet here we have below 35 in a whole number of facilities with very high margins. So it strikes me that we've brought capacity into the system that has high margin.

I note that, as we did two years ago, there's a very low Medicaid percentage. So obviously one could get a little bit more occupancy by taking some Medicaid patients but that obviously would have some effect on margin. These things seem to run together, low occupancy and high margins.

Again, having that kind of investment in capacity that isn't fully utilized just strikes me as a bizarre set of investments for us to have.

What's the kind of sense that -- are there any plans to increase his occupancy? Or is that outside our --

MR. PETTENGILL: I think it's important to remember here that the group of hospitals that that finding applies to are the orthopedic and surgical hospitals. And the margins that we're talking about here are total margins, not Medicare margins or Medicare inpatient margins. And so they have very low occupancy on the inpatient side and they have high costs on the inpatient side, and in fact they're almost certainly losing money on the inpatient side. But most of their business is outpatient business and private payers are a much bigger fraction of their patient load than would be the case say for heart hospitals.

So I think that's what reconciles all this. They're making a lot of money on outpatient activity, primarily in the private sector.

MR. MULLER: Again, I would assume, as we find in other hospitals, they would lose money on their outpatient side in Medicare or not? Do you have numbers on that?

MR. PETTENGILL: I don't know.

MR. MULLER: We always have -- that's more general community rates. We have like minus 12 or minus 15 percent margins across the whole book of business on the outpatient side normally. But my guess is about the full array of services, they may not have that so it may be too hard to extrapolate.

DR. STENSLAND: We have that data but not with us here. We can get back to you on that.

MR. HACKBARTH: And the ortho surgical hospitals are very small, on average, 14 beds. So the difference between a 25 percent occupancy rate and a 60 percent occupancy rate is a few patients a day.

MR. MULLER: And they're almost like a big surgery center. In a sense, when you have 35 percent on 20 beds it's like a surgery center with a few beds attached almost. If you think of a mental image of what they are.

DR. REISCHAUER: These are occupancy rates on 365 days a year? Because I would think small physician-owned facilities would maybe close down for a couple of weeks and Christmas.

MR. MULLER: Open Tuesday and Wednesday.

DR. REISCHAUER: So you've got huge variation.

MR. BERTKO: Jeff, can I ask a follow-up question to slide 16? The numbers here, as you've displayed them, are pretty small, 1 percent. And I guess it's clarification here. If you do the multiplication at 26 percent market share, that looks like it's an increase of about two surgeries per thousand Medicare beneficiaries, if I'm interpreting that about right.

DR. STENSLAND: That would be about right.

MR. BERTKO: So the next question is can you compare that to something? The number I've got running around in my head, from the back of here is that it's a total of about 60 to 70 admissions per any thousand Medicare members. And again a second one on cardiac care is about 1 to 2 percent, so maybe 10 to 20.

My question there would be a follow-up point might be that increase of two compared to 10 or 20. If it's compared to two, I'd say that a 20 percent increase in supplier induced demand is a pretty big number. If it's part of some much bigger denominator, perhaps then you don't worry about it.

Am I thinking about this correctly?

DR. STENSLAND: The typical market had about 32 cardiac surgeries per 1,000 Medicare beneficiaries. So then you're getting back, it's still closer to around that six, or a little less than 10 percent. It's not nothing but it is -- and there's also, I've got to remind people that there is a confidence interval around here. We're not saying it's exactly 6 percent. It could be a few percent lower or a few percent higher because we have a limited sample of data.

MR. BERTKO: So that might be another follow-up point, looking at the Wennberg small market analysis and say where do these kind of places, markets with specialty hospitals fit in it? While the costs all seem okay for cardiac, the supplier induced demand might be something we should be worried about.

DR. CROSSON: I think maybe I have a little different perspective. I'm fully aware of how politicized the issue has become since we started talking about it two years ago, almost two years ago.

But it seemed to me at the time, when we discussed this, we were saying what do we think about this phenomenon? Is it a good thing or a bad thing? Because there are certain aspects of innovation and perhaps useful competition

that are inherent in this and a desire to not simply stifle that out of hand. We had two concerns at the time and inadequate data or early data to analyze it.

One was was this going to have a progressive deleterious effect on community hospitals? And therefore, for a whole range of reasons, that would outweigh the inherent value that we saw in it.

And number two, was there something inherent in this that was, in fact, an obvious conflict of interest as it related to the physician ownership piece?

I think, as we then went further on, we said well let's follow this for awhile. But in the meantime, as part of a larger set of questions, we should at least recommend a level playing field with respect to payments. And we recommended the rebasing of the DRGs, which apparently is going forward.

So assuming that that does go forward I guess I wonder now, two years later, whether we have sufficient reason to believe that either one of our two concerns are manifestly true. Because I don't see it in this data.

So I guess that would lead me to say we should be more cautious rather than not at this point, since the

evidence is not mounting, at least one from what I can see here, the evidence is not mounting to support either at significant deleterious effect on community hospitals or an obvious impact of so-called conflict of interest on the part of physicians. That's what I see in the facts. And if that's not the case, then I'm wrong. But that's what I see.

We were worried two years ago about, at this point, seeing significant harm to community hospitals and seeing data that appeared to show progressive financially driven decisionmaking on the part of physicians. And I don't see either one of those.

MR. HACKBARTH: I suspect we'll have some people who want to think about that and respond to it. Let me just proceed with the queue and then we can tackle Jay's questions.

MR. DURENBERGER: Jay has asked my first question, which relates particularly to conflict of interest. Arnie just mentioned another one, which was the volume increase issue.

But my other question deals with the nature of both cardiac surgery, orthopedic surgery, and other surgeries. And it's an apples and oranges question. When

we compare beds and beds and beds and beds, we don't recognize the rapid changes that take place in the application of technology to orthopedic surgeries, cardiac surgeries and other surgeries.

While I understand what the data tells us for this purpose, I don't understand how we can compare an orthopedic hospital bed with a community hospital bed unless in every community hospital there's a dedicated orthopedic bed or a dedicated cardio or thoracic or something bed, which I don't assume there is.

So what's that got to do with costs -- I'm getting to the cost. Does it cost the same thing to build a bed or design a bed and equip it and so forth in a community hospital as it does in an orthopedic hospital? I'm assuming it costs a lot -- probably costs less in an orthopedic hospital. But I don't know because I don't have that kind of information.

Is that an inappropriate question?

DR. STENSLAND: I think that relates a little bit to the depreciation number, that you have this apples and oranges situation, where you do see a little higher depreciation in these specialty hospitals. We can't exactly

say how much of that is due to them being newer facilities and how much of it is due that they have a different service mix.

For example, if their patients are using the OR and the equipment in the OR, maybe it's a more capital intensive kind of an operation.

So it does fit in there. We have to have some sort of caution in our 4 percent depreciation figure. The occupancy, I think it's pretty straightforward. In some of these cases they did tell us on the weekends we're kind of shut down.

MR. DURENBERGER: And I think this was a poorly stated question. I think about my recent orthopedic surgery, relatively minor. But I was in a big public hospital, in their main OR, and I was in there because there isn't some separate ortho OR or something like that. But I think if there could be a separate ortho OR, unless you tell me no, all operating rooms have to be the same, they have to be equipped the same, they have to be staffed the same, all the rest of that sort of thing. Somehow I don't believe that.

So I'm getting at the apples and the apples and

the apples versus the oranges when we compare costs and margins of an orthopedic or other surgery facility, specialized surgery facility with a community hospital.

DR. MILLER: Can I try something here? I'm not 100 percent sure I've got a grasp of with your question. But I thought what they were saying when they want through the result on the orthopedic is this is a different animal. And I think Ralph ended up with the kind of one sentence version of it, which is when you make these comparisons and you find this drastic difference between the occupancy rates, to take Ralph's view on it -- but I think these guys were saying it as well -- these are basically outpatient operations with some beds. And so the occupancy rates are considerably lower.

In that sense it is a different animal. And I think that's what they were getting across. But I'm still not sure that's your question.

MR. DURENBERGER: No, it is my question and I'm raising it only because when we take summary information and we pass it on to people that don't spend the amount of time trying to analyze it that we spend here trying to analyze it, they may come to very different conclusions, unless they

have something like Ralph to raise the kinds of questions that he raised.

DR. MILLER: We could think about sending Ralph around.

First of all, I think your point in this room and this slide is well taken because people could walk out with the slide and end up with different conclusions.

In the chapter however, I think this point is drilled pretty hard if I remember the text right. I could take a nod from one of you two, if that's true.

DR. STENSLAND: One thing we can do to clarify it is maybe we could you put in some -- the lower 10 percent occupancy and the upper 90 percent occupancy for orthopedic hospitals and their peers. Because we do see some range, they're not all the same thing. We're reporting the median. But we do see some orthopedic hospitals, in particular some of the peer hospitals stuck in my mind as having some fairly high occupancy rates.

So that tells me well, it can be done. It's not like it's technologically infeasible to have a high occupancy rate in an orthopedic hospital. It's just that some of these orthopedic and surgical hospitals, in some

cases they used to be ASCs and when they become a hospital they can get higher outpatient rates and they can also engage in more imaging and things. So there is some rationale behind pure efficiency for becoming a hospital.

MR. PETTENGILL: It's worth noting that even among the orthopedic and surgical specialty hospitals, there's quite a range in size. There are quite a few that are under 10 beds. But there are some others that have 60 beds. So they're not all the same thing. And the occupancy rates are similarly variable. There are a few hospitals that have occupancy rates over 60 percent but not many. Most of them are lower.

MR. DURENBERGER: Mr. Chairman, I am only raising the question because of we're concerned about saving community hospitals from whatever this phenomenon is, then that's one issue. If we're concerned about accessing beneficiaries to the highest and best and the latest and whatnot, then that's a whole another question or it seems to be a whole another question. I know we're working our way towards that one but I'm not sure that we're more than halfway there.

DR. REISCHAUER: Dave was talking about apples and

oranges. I think I'm going to slide into kumquats here.

This maybe is a question for Nancy more than anybody else and I want to know how to think about capital costs in a physician-owned enterprise. If capital costs are high, isn't the equity of owners increasing? And so in a sense this should be on the physician reimbursement side?

You know, in a non-profit situation the capital gets paid for and then a non-profit owns it. In a physician-owned enterprise it ends up being an equity position of the physician who then can retire, sell out and walk away. No?

DR. KANE: I don't think that's how their measuring it. They're taking the actual write-off of the acquisition costs of the building and the materials, the building and equipment and then adding probably the borrowing costs for the building and equipment. There's an interest expense that you were mentioning. I don't think they're taking the accumulated -- I don't think the return on equity is being consider part of the capital costs of these things yet. It doesn't look like that's how you did it. You said depreciation and interest.

DR. STENSLAND: What we did is we --

DR. KANE: But you're right, that would make it even higher if you added the equity takedown after -- if you take out the equity later.

DR. STENSLAND: We consider depreciation a real expense. I guess the financial analysts could do this two different ways. In one they consider depreciation is really an expense, things are wearing out. And sometimes they just look at the cash flow and say this is a non-cash expense. And maybe that building really isn't becoming less valuable over time and then you wouldn't take it out. But we did take that out when we looked at the relative profitability of these things.

In terms of the interest expense, because what usually happens, often for the community hospitals you get a lot of the money donated to build your new building. With these hospitals a lot of times they're borrowing a lot of the capital to build the facility. So there's kind of a difference in the financing mechanism there.

Therefore, we brought that back out. So these are costs exclusive of interest because we didn't want to, in essence, make the physician-owned hospitals look less profitable just because they're borrowing the money to build

the hospital rather than having the money given to them to build a hospital.

MR. HACKBARTH: I want to go back and take a stab at Jay's question. My personal bias is in favor of more competition, not less. To the extent that we identify problems I always want to, where possible, use the least restrictive alternative, restrictive in terms of reducing competition for dealing with the problem.

Issues about competition among hospitals are not new. Complaints among hospitals about their competitors are not new. Many of the same things being said about specialty hospitals have been said by not-for-profit hospitals about poor profits and by urban hospitals about suburban hospitals. That's just, to me, in part the nature of competition.

Given that, my preference has always been first and foremost let's fix payment problems which level out the playing field. We've made our recommendations on that and I'm hopeful that significant headway will be made there.

I happen to think, and this is just my personal hunch, that if that were to happen that would significantly, in and of itself, dampen investment in physician-owned

specialty hospitals. I'm not sure that it would eliminate it but I think the rapid growth that we saw in 2001, 2002, 2003 would not be continued under a fair payment system.

To take the added step of outlawing this type of institution, just a priori we won't permit it, to me requires a really compelling case because of my preference for competition. And like Jay, I don't see that threshold as having been met to this point.

As I look at the evidence I see a mixed bag. There are pieces of it that are somewhat troubling but not so much so that I think they amount to a really convincing case that this is absolutely a bad thing.

As I said in our previous discussions of this, I have some sympathy for physicians about the challenges they face in at least some hospitals in getting a practice environment that allows them to practice efficiently and practice high-quality and high satisfaction medicine for their patients. Those are real tangible issues at some places. And this is one type of response that physicians can take under those circumstances. I have some sympathy for that.

I've been particularly interested in evidence

about the quality of care because to me the hypothesis that you might be able to produce a higher quality of care in this sort of setting is not an outrageous one on the face of it, that you might be able to organize the process differently, hire differently, staff differently to produce a better product.

To this point the evidence, as I understand it, with regard to cardiac care, which I think has been most studied, is that well, there is some evidence of improved outcomes but they may be accountable based on size and the amount of surgery being done as opposed to something inherent in physician ownership. There is a fair statement?

I think that's an issue that needs to be studied further. Again, I don't think it's an outrageous idea that this sort of organization might be able to improve quality.

Given the challenges we face with quality in our health care system to just a priori say this is outlawed, when the evidence is this ambiguous, I think would be just a real public policy mistake. Not looking for the least restrictive alternative but for the most dramatic alternative.

So let's fix the payment system and I think that

will largely resolve the issue. And then let's let the evidence accumulate a bit and see what it says.

MR. MULLER: I remember the data differently than you just summarized it. My memory of our information a year-and-a-half ago was that the severity was much less in the specialty hospitals and therefore when you have lower severity even within a DRG, you should have a better outcome if the outcome measure is not appropriately severity adjusted.

So the why I would read that -- I'm trying to remember now, I haven't looked at the chapter in over a year. There's anywhere from 20 to 50 percent difference in the severity which one might mitigate with the APR-DRG system. But there was quite a big difference in severity between the specialty hospital mix and the regular mix. So therefore one should have much better outcomes with that --

MR. HACKBARTH: What I'm referring to Peter Cram's study at Iowa which to the best of my limited knowledge is the one that's taken the deepest look at quality differences for cardiac care. I think he adjusted for severity differences, found slightly better outcomes. But his hypothesis that that might be attributable to scale. Is

that a fair summary of his work?

DR. STENSLAND: I think he said that on average, controlling for severity, the specialty hospitals looked a little bit better. But then when you also controlled for size they didn't look any better. So once you control for size and severity, he basically said there was no difference.

I think the one cautionary tale we get from our specialty hospital volume chart that we see out there is not all physician-owned special hospitals really have high volume. There's a couple of them that are really low volume facilities. So we can't just always categorize physician ownership equals high volume.

MR. HACKBARTH: I vaguely recall that there was also a more recent study done on quality in orthopedic and surgical hospitals.

DR. MILLER: That's not out.

MR. MULLER: Just looking at slide four on the geographic dispersion, the concentration, and my memory looked remarkable similar to the graph we had a long-term care hospitals before they started diffusing around the country.

Obviously, with the certificate of need limitations in most of the Eastern states, in the green, you could see why before the moratorium they perhaps didn't get there. Obviously without a moratorium -- and if the payment changes go through then I think I agree with Glenn and Jay that that should have a big effect on the spread, if in fact those changes are made.

If they're not made, one could certainly see the concentration that's basically in the southern middle of the country now going to other parts of the country because they would be seen for a variety of reasons as very attractive places to invest with 30 or 40 percent rate of returns for one set of them and so forth.

Obviously, the extent to which those rules have now been announced, those you pointed out earlier today in another setting, they may be implemented in a two-year period rather than a one-year period. When we made our recommendations a year or so ago, we had preferred they be implemented in one stroke together, rather than over a period of time.

MR. HACKBARTH: Just a couple of quick reactions to that. Within our system if there are states who don't

share my preference for competition and who are very concerned about this development, they can prohibit it and we don't have to do it on a national basis. We can do it on a more local basis. That's point number one.

Point number two is I'm troubled that we have some people, some organizations, simultaneously arguing that we shouldn't refine the payment system and we ought to outlaw physician-owned specialty hospitals. They're doing what they can to block more accurate payment. And then they also want to block competition. That's a combination that I find especially unpalatable.

DR. MILSTEIN: A couple of comments and then a question.

First, I'd like to join the chorus of those who believe that competition that would likely benefit the Medicare program and all of their payers and that we ought to be biased substantially in favor of embracing innovations that appear to be a more cost-effective means of health care delivery than what we've got.

That said, I think that we have evidence in this presentation that simply better tuning the payment system ain't enough. If we could just put slide 15 up there, it

is, I think, a nice anchor point.

Slide 15 shows us, in the far right-hand column, that we have a 2.5 point impact on rate of growth of procedures associated with introduction of specialty hospitals. I submit to you that a 2.5 point opportunity in growth of services, absent pre-existing evidence that there was some kind of a supply constraint, which we don't have here, is fairly alarming from the point of view of sustainability of the Medicare program. If anything, we ought to feel comfortable at approving things that generate a 2.5 point increase in volume. Absent evidence that that's more than offset by some reduce in unit price, it would be enough to take our unsustainability and the actuarial projections for Medicare into a very alarming place.

So as I look at the evidence I come at it a little differently than Jay for that particular reason.

My question really relates to this. As I'm thinking about cost comparisons between these focused factories and general acute hospitals, it's obvious that one of the costs that we need to make sure we account for in doing these comparisons is the cost burden on the community hospital of stepping in when things don't go well in the

specialty hospital. I'm wondering whether or not -- I'm trying to remember back in our prior calculations whether at any point along the way we attempted to factor in to the cost comparison the incremental cost burden on the community hospital of providing the backup capacity to handle cases that go wrong in the focused factories.

DR. STENSLAND: I think from the orthopedic and surgical hospitals, the number of cases that go wrong, if I remember right from our last analysis, it was pretty small. That's often because they specifically don't want those cases. A lot of times they tell us they only want people with anesthesia risk of one or two, that aren't going to give them any trouble, so they know when they'll go in, they'll know when they go out, and they can keep their operating room humming.

The heart hospitals, I still think those cases are also fairly small. And they were, I think, able to handle most of their cases. And the number of transfers were fairly small there, too. There would be a small number of, I guess multisystem failures they would have to deal with.

DR. MILSTEIN: That's reassuring, although a small number of cases that have a very big cost tail might inform

this comparison, at least on heart hospitals.

DR. STENSLAND: Maybe the one last thing on the standby capacity, that is probably a real issue. Not so much that the community hospital has to have more standby capacity, it's that the heart specialty hospital doesn't have to have standby capacity. So sometimes we see these places with very high occupancy because if they don't have any room then they just send the person to the community hospital.

DR. MILSTEIN: Is it feasible, within a next iteration of this, to attempt to bring into that cost comparison those two factors? Or is that beyond what our current database would allow?

DR. STENSLAND: It might be difficult to get that done. We would have to conceptualize exactly how we were going to do it first.

DR. MILLER: I would have even chosen a word that's bigger than difficult. Particularly the transfer point of the case at a point when it's okay, I've got a problem here, I need to send it out of the specialty hospital to the community hospital and it's something that went south on the physician.

We, in the last report, looked at some of the transfer patterns. And it got pretty complex and started to stretch the limits of the data, as I recall it.

We will absolutely take another look at this but I don't want to promise in this room that that very question can be nailed down. I remember us getting well past the limits of our data in that analysis.

DR. REISCHAUER: The right thing to do would be to take the cases that go wrong over and above what would have gone wrong in the community hospital, so it makes it an even smaller number.

DR. MILLER: I think that's the word that's bigger than difficult.

[Laughter.]

DR. MILLER: I was just reading that section of the report and remembering how complicated even what little we had here got.

DR. SCANLON: I do think that just as a first step the payment changes obviously -- I mean, there's no way that reasonable people should oppose it and it will probably have a big effect.

But in terms of the impact of the specialty

hospitals, I guess I believe the evidence is not necessarily sufficient now to reach a strong conclusion in either direction.

Part of it relates to how I feel about competition in health care. While competition is normally a good thing, part of that is based on the premise that demand is fixed and that suppliers are going to be competing either through quality or price to try and get a bigger slice of the demand that's out there.

The reality in health care is that we've seen over and over again that suppliers can influence demand. The fact that we've seen to date potentially less impact on community hospitals, we've said that part of that is the community hospitals have managed to increase demand for other things. And over a longer period of time we may see that one of the consequences of having more capacity for cardiac hospitals is that we have more people going into that specialty and we see even a bigger increase than what Arnie just pointed out in terms of this response over this short period of time.

So it's the suppliers response that worries me in terms of how do we use competition? Do we really fully have

control over the consequences of it, that applies, I think, in this case?

The other thing that makes the evidence right now more preliminary for me is we're still dealing with an anomalous period. We're dealing in some respects with the start up period of specialty hospitals that got interrupted by a moratorium. They were influenced as to where they were located by certificate of need, which isn't necessarily completely arbitrary where that is. There's some selection on the part of the states.

You mentioned I think that they've gone into the higher growth areas for the most part. So in some respects the community hospitals maybe were in a better position to absorb some of the loss.

And we're still doing, in some respects, with a fixed supply of physicians in all of these communities which influences the result as well.

So I guess I worry about supplier induced demand, which maybe is partly an answer to Jay's second question. And I worry that we haven't got enough evidence about the impact on community hospitals right now to say one way or the other how we should feel about specialty hospitals.

MR. HACKBARTH: I just want to be clear. I was just playing back in my own mind the things that I said. I want to be clear that I'm not an advocate of this. I'm an agnostic. I just don't think that there's a compelling case on one side or the other.

The issues about induced demand in health are very real but they are not unique to physician-owned specialty hospitals. And if there are states that want to constrain the supply of providers, not just this but others as well, because of a fear of induced demand they are able to do that and they can adopt their CON and make it as tight as they want to make it.

But currently that's not the national policy and there may actually be some merit in having different approaches to that.

DR. SCANLON: I wasn't trying to limit the concern about supplier demand to specialty hospitals either. In fact, I was trying to raise the point that the community hospitals' response could be supplier induced demand. And THAT we should be just as concerned about that as we are about what might be happening with respect to the specialty hospital.

MR. MULLER: If we can go to slide 13, too, I think that while we can go about the virtues of competition and what it does to care, I think one of the side effects of competition is shown here, which is that they don't take Medicaid or take much less. I think just around the country the kind of profit margins that come from the not taking Medicaid are well known. They're take a far lower share just because by and large Medicaid is the lower payer than Medicare.

So obviously we've shown in here that Medicare is roughly one-third to 40 percent of the market. So therefore, with the lack of Medicaid population, it's largely private. So in some sense this issue is more in the private market and we've talked in the past about the relationship between private payments and Medicare payments.

But I would say of the slides that we've shared here, I mean one thing I've really focused on is this low Medicaid shares, which is probably the biggest driver -- rather than being a focused factory -- it's probably the lower Medicare share that drives the profitability more than any kind of focused factory or better outcome.

MR. HACKBARTH: If you look at any of those

categories and look at the variation within the categories, you'll see wide variation in Medicaid shares among community hospitals as well.

MR. MULLER: But it's well known that if you have a high Medicaid share, like the public hospitals' 40 or 50 percent, that they're the ones that have -- I mean the public hospitals have very low margins.

MS. BURKE: I was going to raise the same question or at least concern about the Medicare numbers, simply to suggest that it's something I think we do have to keep an eye on because I think it has an impact in terms of margins.

But just on the broader policy question, should we in fact encourage or see the development of a delivery system that routinely doesn't care for a segment of the population, in this case the Medicaid population? Irrespective of the margin question, I think it's just a fundamental policy question. Do we want to see that or encourage that kind of behavior?

But the other question that I wanted to note, and it's following up in part on Bill's comment, which is that I am a little troubled by the statement that suggests that we needn't ultimately worry about the impact on community

hospitals and their relative margins because they just went out and found different ways to make money. I'm not sure that's inherently a good answer. It may be the right answer, it may not be a good thing.

So I think again getting some handle on whether or not we are encouraging behaviors because we are allowing delivery systems to essentially fracture, I mean I'm like Glenn, I'm somewhat agnostic on this question. And I do understand and appreciate the difficulties of physicians' experience in scheduling and managing patients and the ease with which you can do it in a smaller setting that's more controllable and predictable and has the capacity for dealing with a certain kind of patient.

But having said that, I do worry and I do hope that we continue to try and understand fully the impact on community hospitals and what's really going on in terms of their behavior and their response.

Because I don't think we should feel better simply because they went out and found a different way to make money because these patients are, in fact, being drawn away and cared for in other settings that may or may not be an efficient setting.

So again, I don't presume to know that based on the report, which continues to be very helpful in helping us understand this question. But I do think it's something we need to continue to probe and understand because I don't necessarily think that should always be the answer we are searching for, which is okay, we'll cut you off here, now go find some other way to do it. And then ultimately, we become concerned about the other way they found to do it, inducing demand in other areas.

So I just think we need to keep a close eye on that but I do want to understand more fully this Medicaid question. It continues to be a population that is vulnerable and gets shifted around. And I don't think we ought to encourage behaviors or payment systems that essentially allow them to continue to be isolated in terms of where they seek their care.

DR. REISCHAUER: Just to defend the analysis of the staff, they answered the question that was asked, which was --

MS. BURKE: It was not meant as a criticism.

DR. REISCHAUER: -- do these hospitals undermine the fiscal health of these other, not is it socially

beneficial that this happens.

MS. BURKE: I understand that and it was, by no means, meant as a criticism. They've done a terrific job. My point is simply I think as we continue to look at this question that's a question we ought to understand more fully, not that you failed to do exactly what we asked you to do.

As usual, you exceeded all expectations in all ways, for which we are eternally grateful

[Laughter.]

MR. HACKBARTH: On that note, we will move ahead. Thank you very much.

DR. CROSSON: Just on this question of induced demand in the community hospitals, did we have evidence of that? I thought we had evidence that they had fixed their margin problem; right?

MR. HACKBARTH: There is the evidence about the increased rate of cardiac surgery.

DR. CROSSON: No, in the community hospitals. I thought we had evidence they had fixed --

MR. HACKBARTH: We had anecdotal information about how community hospitals responded to the competition and it

was a mixture of things. Some of it was reduced costs. Some of it was new services that were profitable and replaced the lost business.

To the best of my recollection we actually had no hard-core analysis. It was just information that we picked up from our site visits; is that right?

DR. MILLER: I think that's right, and Jeff you should get into this. One of the questions that the higher utilization in the markets with specialty hospitals raises is is some of that happening because the community hospitals backfills by restarting a heart program that they lost or something like that?

But it's not like do we know that is all the community hospital? No, we don't have a direct -- but behind that aggregate number, it's sort of how is that actually occurring? It could be that the community hospitals are backfilling.

DR. STENSLAND: I was going to say is it anecdotal evidence and we only have one of the providers that was actually very kind to actually break it down to us. They said we lost $2 million and we set up an imaging service with some of our radiologists and we gained back $400,000.

Then we set up a pain management clinic and we gained back $300,000.

MR. HACKBARTH: What they did was just increase the size of the radiology service that they were going to do anyhow.

DR. STOWERS: We keep talking the difference in competition but we've got to remember the first time we went through this the competition wasn't all about financial. It was about getting better services and getting later equipment that they couldn't get in the community hospital, which a lot of those things brought better patient care and efficiencies and so forth.

We seem to be all talking the money part of it and there isn't a big case here for the money part. So I think we need to keep in mind what really stimulated the growth of these in the first place, and it all wasn't financial.

MR. HACKBARTH: Okay, thank you very much.

Now we're going to move to a series of three very brief sessions on hospice, home health process measures and Medicare's use of clinical and cost-effectiveness information.

Just to help the people in the audience get

oriented, these three sessions are going to be very brief, hopefully no more than 10 minutes each. And they are a recap of work that's been presented at previous meetings. And the purpose of these very brief discussions is just to make sure that we've captured critical points that Commissioners have made in previous discussions. So this isn't going to be a long new presentation but simply a quick summary on each of these issues.

First up is hospice.

MS. LINEHAN: First I want to address a couple of questions that some of you raised at the last meeting. We looked at the 2002 and 2003 claims data for what we could know about a non-profit and for-profit patient population differences. We found that a greater share of beneficiaries in non-profit hospices had cancer diagnoses than in for-profit hospices and also had shorter mean lengths of stay in hospice than patients in for-profits.

We also looked the type of days of care, which is a question that I think Bob had asked.

If you will recall, the hospice care is paid at one of four daily rates. The default type of day is routine home care. Over 90 percent of days in both for-profit and

non-profits are routine home care days. The difference between the two, for-profits and non-profits, was the share of days that are in continuous home care, the continuous home care rate, which is at least eight hours of continuous home care with at least half of the care provided by a nurse, an RN.

Continuous home care days were 2.6 percent of days in non-profits and 6.8 percent of days in for-profits. But like I said, the vast majority of days in both types was still the routine home care days.

I just wanted to call your attention to, and this was a point that Sheila had raised, about wanting more information about how the patient populations had changed. And I added to the chapter there about the nursing home patients and the diagnoses.

Just briefly, the findings of the chapter were that the PPS was developed about 25 years ago using data on patients with terminal cancer. Patient changes, modality changes, though we can actually know little about this using Medicare data, suggests that the hospice payment system should be reevaluated to assess whether the payment system pays accurately for the costs of the contemporary hospice

patient. We can't do much with Medicare data so we used a large chains' patient level data.

RAND did this analysis for us and they had two basic findings: one, that patient demographic and diagnosis data didn't improve the ability of the payment system to explain variation in visits and visit labor costs; and that the beginning and end of hospice stays were more intensive than the middle days.

I want to just caution you again that the results from one chains' data may not be generalizable to all hospices.

So the results of RAND's analysis didn't provide evidence that case-mix adjusters would improve the accuracy of the payment system. But they do suggest that redistributing payments for the first and last days of care may improve payment accuracy. But we need to test these findings with additional data.

To answer questions about the care that's provided to hospice patients and the ability of the current payment system to explain variation in the costs of care the program needs to collect additional data like the number, type and duration of visits, drugs, patient location, none of which

it currently collects.

In addition, in the future, this Commission could pursue an analysis of payment adequacy like we do in other settings.

Now I'll take your comments on whether we've captured what you suggested in March.

MS. HANSEN: Just a clarification, Kathryn, with your last comment that since patient location isn't captured. I was thinking about the change of diagnoses over time that not-for-profits have a little bit more of a cancer diagnoses as compared to the others.

I guess the question that I have, and I looked at the graphs here, the growth of the freestanding hospice programs, would that be an example of a freestanding program having the opportunity to provide hospice services in a nursing home setting? So these are not nursing home sponsored hospices but freestanding ones providing services in the nursing home?

MS. LINEHAN: Sure, yes.

MS. HANSEN: And that's where I just wonder whether that kind of length of stay and all those things just kind of, without the analysis, seems to be correlated

to people who are already in nursing home beds and therefore the ability to provide hospice program services has grown quite a bit.

MS. LINEHAN: Yes. I think that's one of the key things we'd like to look at. We can't know where the patient is from the claims data. There are a couple of ways that other studies have tried to get at whether a patient is actually in a nursing home when they get their hospice care.

The best way to do it would require you to match the patient level data to the MDS, the choice of the patient assessment in the nursing home, which is a really big data job. But that's really currently the only way you can know whether somebody is actually in the nursing home.

MS. HANSEN: For some reason, for the first time, this just struck me that there is such a strong correlation to that. When that new option became available, was it in 2000 --

MS. LINEHAN: To provide hospice to the nursing home patients? I think it was '86, actually. But that's a hypothesis that we'd like to look at, tying up the diagnosis, the location and length of stay.

DR. MILSTEIN: One of our prior observations when

we last discussed this that I think might warrant inclusion in our list of conclusions was that case-mix adjustment could well make a difference if a wider set of patient morbidity characteristics were collected. We were looking at a quite impoverished set of patient characteristics which we then said does this impoverished set -- which is actually a set of convenience, not a set that we thought might be predictive of differences in patient morbidity and therefore service need. We tested that set and concluded that case-mix adjustment would not make a difference. But that does not, in turn, support the conclusion that case-mix adjustment might be warranted in relation to these services.

We could slightly modified the -- expand the first conclusion. And I personally hope that we would advocate that such a more deliberate -- that a more deliberate set of patient morbidity characteristics be collected -- be found and/or collected and tested before concluding that case-mix adjustment would not make a difference.

DR. MILLER: No, I agree that we can be much more careful about how we state the conclusion. I think Kathryn's point about the generalizability was a very short and summary way of saying that. But we can be much more

clear in the chapter.

I guess the other thing that occurs to me, and I'm asking Kathryn, when we talked about these -- did we talk about these results with people out in the community? And I can't recall, I have a sense that we did that and I was trying to remember whether people were surprised that case-mix did or did not explain it. I have this vague sense that some people weren't particularly surprised given what goes on with patients in these settings.

MS. LINEHAN: Well, RAND had clinicians on their team and they weren't particularly surprised by this result. But whether that is representative of the community and what their response would be, I don't know.

DR. MILLER: That was the data point I was looking for, is they did actually run some of this past their clinicians. And I remember some comments along these lines of them not been entirely surprised that that was the case.

MR. HACKBARTH: I agree with your point, Arnie, about softening the message just a little bit, although I must say it struck me as intuitively plausible, possible, that in fact a diagnosis may not be a good predictor of hospice service use. But that's a long way from concluding

that it is not.

DR. MILSTEIN: I was also thinking about other cost predictors like circumstances of home environment, et cetera, that were not tested.

MR. HACKBARTH: Anybody else?

DR. KANE: [off microphone] A clarification on page 14 of your paper. You mentioned that in 2000 and 2004 more than 25 percent of beneficiaries were dying in hospice but they been involved for less than a week and that's not optimal. I guess I wasn't sure what that means. Optimal amount of time? And could it be due to the nature, the mix of patients why that might be shorter? People don't know [inaudible].

Did you have something in mind? I don't understand that what was, not optimal.

MS. LINEHAN: I guess because -- well, there's literature on -- and I can sort of add more to that about -- that a longer length of stay might allow a patient to benefit from more hospice services like bereavement counseling, maybe would allow their families to benefit.

But given that the benefit is for six months, I guess part of the idea behind that, too, is that if we think

that six months would allow somebody to benefit from being in hospice but they're in there for three days or five days, that perhaps they don't get -- they don't get from the benefit all the services that are offered under the benefit.

MR. HACKBARTH: I think it's a good catch, Nancy. I think a little bit more elaboration is required to explain optimal in this context.

Other questions or comments on hospice?

Okay, let's next move on to home health process measures.

MS. CHENG: My part of the summary is to revisit the chapter on adding quality measurement to the home health current measure set.

This chapter is part of the Commission's agenda on measuring quality and moving towards pay for performance. In 2005 the Commission identified this sector as being one that was ready for pay for performance and we said at that time that we would also like to see the quality measure set continue to change and evolve.

We thought that adding some measures to the set that we have currently in home health could broaden the patient population that we're able to measure, could capture

safety as an aspect of quality, could measure an aspect of care that is directly under the providers' control, reduce variation in practice, and also perhaps provide incentives to adopt or improve information technology for the providers in this setting.

So as a step toward that we held a panel on best practices. We discussed wound care and fall prevention as the focus of the panel. One of the things that we were asked to do was to add a little text here. And so what we tried to do in the draft that you have right now is to explain a little bit more about why we looked in these two areas.

We found that best practices or processes in these two areas could potentially apply to all patients. They're not condition specific. They could capture safety as an aspect of being able to keep a patient safely at home.

The panel told us that these are two areas where they were very aware of wide variation in practices. So to the extent that introducing process measures could encourage a reduction in variation where variation is caused by not adhering to best practice that we could reduce variation by making these process measures more widely used and known.

We also tried to add some text to emphasize that we understand that the scope of the home health benefit is much broader, that these are just two aspects of things that go on in home health and that the scope if the benefit is wider than these two activities.

After identifying best practices the next step then would be to move from best practices to process measures. We added a little bit more text here to explain a little bit of the science of moving from what we know to be good care to describing exactly what we mean. How do we make sure we're measuring it reliably? What's the denominator? Who should be excluded from it, et cetera. That would enable us to use these as measurements of quality of care.

The Commission said that it's important for all measure sets, not just home health, but all measure sets to evolve. And we know that CMS is engaged currently in some ongoing work to work on process measures and other measures for the home health setting.

So the chapter closes by urging CMS to consider the best practices that we identified with the help of our panel as they explore adding measures to the home health

set.

So with that, I'd like to open it up to make sure that the current draft has addressed your concerns.

MR. HACKBARTH: Any questions?

DR. SCANLON: I think it did 99 percent. I just want to raise was one small point, which is on 14 you talk about a validity test. I think this is one type of a validity test when there can be a correlation between what I might think of as an outcome measure and the process measures.

But if we have a desire for process measures because we can't measure outcomes, we need to think about other ways to validate those measures because if you do have an outcome measure that you can use to relate to the process measure, there's a question of why don't you use the outcome measure to begin with?

So expanding that a little bit to talk about validation may involve more things, would be very helpful.

MR. HACKBARTH: Okay, Sharon, well done. Nancy?

MS. RAY: This is the last of our 10 minute presentations. I'm here to get your comments on the draft chapter on Medicare's use of cost-effectiveness information.

The chapter focuses on the lack of standardization of methods and results across cost-effectiveness studies.

Recall last month that Peter Neumann and Josh Cohen presented the results of the review they conducted for us. They looked at cost-effectiveness studies for two Medicare covered services, ICDs and screening for colorectal cancer. The chapter summarizes the study's findings.

Despite some variation in the results across the studies, the literature provides an indication of the clinical effectiveness and value for colorectal screening. By contrast, the literature for ICDs does not provide a clear indication of the service's cost-effectiveness because the results vary substantially across studies.

The chapter then goes on to describe ways to improve the standardization of methods used in cost-effectiveness studies with the goal of improving studies' comparability and transparency.

Finally, the chapter points to future issues for Commission discussion, issues involved in Medicare developing the infrastructure to consider clinical and cost-effectiveness information, such as who would sponsor research, the public nature of clinical and cost-

effectiveness research, and the role of the federal government and private groups in standardizing and sponsoring this research.

We also raise other future issues for Commission discussion like who would fund the research and what services Medicare could focus on.

Again, we'd like your input as to whether or not the chapter addresses your conversation from last month.

MR. HACKBARTH: Questions or comments?

DR. KANE: My only comment was I thought it did actually. I read the whole thing and thought wow, they really did bring it -- so I thought it was a good job.

MS. HANSEN: Yes. I think, without a doubt, this whole area is always kind of dicey, the comparative effectiveness vis-a-vis the cost-effectiveness. I know that the state of Washington has really moved on this.

So I guess just some continued sensitivity that the cost-effectiveness side doesn't become kind of the larger numerator here, to make sure that the comparative effectiveness balance is just kept.

MR. HACKBARTH: Okay, thank you all.

Next up is hospital wage index.

MR. GLASS: This is a follow-up. We looked at some wage index issues in December and it's kind of an update of our progress. The wage index moves a lot of money around. Looking at the FY '07 proposed rule, the hospital in the highest wage index area gets a base payment of about $6,600 and the one in the lowest wage index area gets a base payment of under $4,000. So it's consequential to hospitals and other providers.

We think a new approach to the wage index may have some advantages, and particularly for the PPSs that now use a version of the hospital wage index rather than one that pertains directly to their sector.

The data we're going to present were developed for us by Abt Associates. They're historical data from 2002 2004. So the results we're showing would be predictive but maybe not precisely what would be expected in the future.

The current approach to the wage index, we've discussed before and I'll just quickly go over, is the data comes from hospital cost reports. What they do is they calculate an average wage for each of hospitals. The calculation is kind of complicated because they have many pages describing what costs you're supposed to include and

what you're supposed to exclude for things like contract labor, home office, and all that sort of thing.

But essentially they use the average wages for the hospitals and then they take those and put them together and calculate an average wage for an area. The areas we're talking about are the metropolitan statistical areas, the MSAs, and the state-wide rural, which is all of the state that's not in an MSA.

You then take the area's average wage and you compare it to the national average wage and that produces the wage index for the area. So if it's a $22 average wage in the area and the national average was $20, your wage index would be 1.10.

They also make some adjustment for occupational mix and we'll get to how that works in a minute.

And then of course, there are the reclassifications and other adjustments that are made, things like rural floors and out-commuting and all that sort of thing. They are kind of exceptions but they change the wage index for about a third of the hospitals

The new approach we're talking about is based on using Bureau of Labor Statistics data. This is data that

the Bureau of Labor Statistics routinely calculates. It's used to calculate a relative wage for each area and we use what we call a fixed occupational weight technique and the data is for all employers in an area.

Basically what the BLS is in each area for each occupation in an MSA and in the state it shows the average wage for that occupation. That's for all employers of that kind of worker. And they also calculate, at the national level, what share each occupation makes up for each industry. So in hospitals 27 percent of the people are RNs in the hospital.

So they do that for each occupation. What we do is we take the national occupational weights, in other words what percentage each occupation is of the hospital's total labor pool, and we apply that vector of weights to the vector of wages that we have for each area, multiply it together and get the average hospital wage for the area.

We decided to take that a step further. That gives us a wage index for each area just like the regular process does. But then we took it another step further and we used census county level data to further adjust just within large MSAs. The objective here is if you have a

large MSA and the central area has higher wages than the outlying counties, this captures that. And that's using the census data.

A possible next step would be to further smooth, you could look at areas with large differences, say a rural area in the neighboring MSA. And you could further smooth there using other techniques such as blending the wage index. And our contractor, Abt Associates, is looking into how you might do that right now. And that could be used really with any wage index, with the current one or with the one we're proposing.

The differences between the approaches, just to summarize that, the current approach uses hospital data only as opposed to data from all employers under the new approach. That actually could be a profound difference because it kind of brings up what is the goal of the wage index. And we're going to talk about that more at the end of the presentation.

The basic question is should the wage index reflect hospital only data or the prevailing wage in the area for a specified mix of occupations? And it kind of goes to the question of do the hospitals compete with other

employers for their labor? Or do they exist in a pool to themselves?

The other difference is that the current approach uses one year data from the cost reports. So to figure out the 2004 data we're going to show you, they used the 2000 cost report. The BLS number for 2001, which would be what would be available to set the 2004 index, is a three-year average of 2001, 2000 and 1999 data. So BLS is always a three-year average.

The current approach has to do an additional survey and then a further adjustment to the wage index to come up with an adjustment for occupational mix. The new approach you would just automatically adjust for occupational mix because we used that fixed weight approach where we're using the national weights. So we don't have to do anything more to it.

And finally, there is this question of all of the exceptions made to the current rule, reclassifications and that sort of thing. And the basis for the reclassification -- where there is one -- is the average wage. And since you wouldn't necessarily calculate that anymore on a hospital-by-hospital basis, that basis for reclassification is

removed. So you may end up with fewer exceptions under the new approach.

For some reason missing here is a slide on volatility. Basically, the new approach is less volatile over time than the current approach, depending on what level you do it, at the hospital level or the wage index area level. The volatility is about half, a couple percent less, in the 90th and 95th percentiles.

The occupational mix problem is that two hospitals could pay similar workers exactly the same kind of wages. So they could pay RNs $30 an hour and LPNs $15 an hour. But if they have a different mix of workers, if one uses more RNs and fewer LPNs than the other, they will have a different average wage. And since the point of wage index is to understand the underlying wages in the area, you don't want that choice of occupational mix being used by a particular hospital to be figured into the wage index.

So under the current approach they have to adjust it out. And the way they do that as they have an additional survey asking hospitals for their occupational mix and how many hours and now how many hours and dollars.

So FY '05 and '06 it was 10 percent adjusted.

They used that occupational mix adjustment to adjust 10 percent of the wage index and 90 percent of it is not adjusted.

In FY '07 they're also proposing the 10 percent adjustment. But the problem is that they've recently lost a court case. And the result of that is that they are supposed to adjust for 100 percent occupational mix. It's not clear exactly what CMS is going to do with that problem at the moment. Either they have to use the old data, which the problem there and the reason it's only used 10 percent is no one is very happy with the current results, or they're going to have to use the new survey which they just put out there and it's not clear they're going to have result in time. So it's not clear what they're going to do.

Anyway, under the new approach, you'd automatically adjust, use the same fixed-weight vector, and you wouldn't have this occupational mix problem.

When we looked at the distributions that resulted, first of all the wage indexes from the current and new approaches are very highly correlated with each other. But the new approach has a slightly tighter distribution. There are fewer very high or very low values. The most salient

thing is that hospitals with very high wage index values in the current approach tend to have lower values under the new approach. So once you get above about 1.25 under the current approach, wage indexes of 1.25, those tend to come down under the new approach.

This is similar to earlier findings that we had in, I think, the June 2003 report which said that in high wage index areas the current index overstates possibly because of occupational mix.

Another thing we did is we tried to look at the explanatory power of the two indices. Here the objective is to test how much the wage index explains hospital cost. We used a multivariate regression model and the dependent variable was cost per case. On the right hand side we had payment like variables such as case mix index, wage index, DSH and that sort of thing.

Basically the result were very similar for the various wage indexes. We looked at the BLS index, we constructed two forms of that, and the CMS final wage index and the CMS pre-reclass index and it all comes out to be very similar.

If you look at a kind of marginal effect thing,

you might find there's a little bit of difference but results seem to be very similar.

The other issue we want to cover is using the hospital wage index in other sectors. Again, most other prospective payment systems, such as for SNFs and home health, use the pre-reclassification hospital wage index. What that is is that's the hospital wage index as calculated by area without any of those exceptions put in.

The concern is, first of all, it's not clear that wages for SNFs and home health agencies vary in the same way as hospital wages do. That would be one consideration.

The other is that when an hospital in an area is reclassified, the SNFs and home health don't get any change to their wage index, but the hospital they're competing with labor for, that hospital has a higher wage index than they do. And so those providers have raised this as an issue of equity.

The new approach would create a wage index for each sector. The area wages for each occupation would stay the same because they're from BLS data from all employers to begin with. The vector of occupational weights would differ by sector because remember that's the national occupational

weights for that particular sector. And so when you multiplied that occupational weight vector times the area wage vector, you'd get possibly slightly different results, but at least they'd appropriate to that mix of employees. So that may be more equitable. We're going to investigate how much of a difference it actually makes.

Because we're looking at relative wages between areas and it may be that that's relatively similar for all kinds of employers. But theoretically, it would be a better model and it does avoid the reclassification problem.

So in summary, the new approach is less volatile, it automatically adjusts for occupational mix, it would reduce administrative burden. The hospitals wouldn't have to produce the average wage data, and CMS could pick up the BLS data instead of calculating their own. It would eliminate the basis for the exceptions that are made now, though there may still be pressure for exceptions to be made, of course.

It would probably be more equitable for other types of providers, that is providers other than hospitals. And the data would represent the prevailing wages in a market.

On the other hand, the data would not be specific to hospitals, which can be thought of as a plus or a minus, and it would create new winners and losers, which of course would make this extremely political.

As I said we'd return to this question of what is the goal of a wage index. If it's role is to adjust payments for the difference in wages across geographic areas, then the question is should the wage index reflect average wages paid by hospitals in an area or reflect prevailing wages that all employers in an area have to pay to attract their particular mix of workers?

You can think of the difference between these two ideas. If you think that actually hospital wages are a perfectly good measure for every -- relative hospital wages would be a good measure for everyone else, then using the hospital wage index for all sectors is probably not a good idea. So the first one, if we think that's important to use exactly hospital wages, then we'd have to probably think of another way to the SNFs and home health and other providers.

The other assumption that we want to do the prevailing wages says that in these markets hospitals are competing with other employers for the same kind of labor.

So everyone's hiring office workers, everyone's competing for the same workers, so we should look at the prevailing wage. Everyone's hiring nurses, security guards, et cetera.

So the second assumption kind of says that everyone in that area is competing for workers and the hospitals don't have a separate pool of workers that they're looking at.

There are two different ways of looking at the goal and we would appreciate your discussion about which one of these we'd like to go with or if you think it's an important distinction.

And also, we would answer any other questions that you may have.

MR. MULLER: David, remind me again in many of the PPS areas we have the wage index, beyond the hospitals? Since that's one of the -- how many other --

MR. GLASS: There's SNF, home health, long-term health hospitals, IRFs, hospice. Almost everything but physicians.

MR. MULLER: To go back to the slide that we have in our packet but didn't get on the public screen, the one that says volatility. The way I'm reading it is under the

current approach versus the new approach, the changes are roughly twice as much. That is the change in the wage index from '03 to '04 is roughly twice as much in the current approach as the new approach. Am I reading that correctly?

MR. GLASS: Yes. I'm sorry, I don't know why the slide isn't here.

But anyway, what it says is that under the current approach the absolute percent change from 2003 to 2004 in the wage index for hospitals is 1.4 percent under the current approach and 0.7 percent under the revised approach. That ratio holds going up to the 90th and 95th percentile.

MR. MULLER: So in terms of how -- it roughly halves the increase in wages under the new approach versus the -- the old versus the new. What's causing that to occur? I can understand some of the technical measures that you referenced in your presentation but I'm just trying to figure out why it would have a -- halving of a wage increase is a big percentage.

DR. ZABINSKI: We're not halving the wage increase. This is just the percent that -- if you look at all of the areas in the country and you look at the wage index in 2003 and then you look at the same wage index in

2004, the wage index for the areas changed because the hospitals report different wage data and all that sort of thing. And sometimes that can change a lot and sometimes it can change a little. And we're saying at the median it changes by 1.4 percent.

DR. REISCHAUER: This is the absolute value. So there are pluses and minuses. This is just a volatility from year-to-year.

DR. STENSLAND: So on average it goes up by 1.4 percent or down by 1.4 percent, on average.

MS. HANSEN: This is more of a question in terms of understanding this. Given the fact that whether BLS includes all employees for that area, as compared to looking at hospitals only, given the kind of targeted issues of again the nursing shortage and some of the areas of the medical technicians and physical therapists, that is addressed in this format? Or not?

MR. GLASS: Those occupations are in there, yes.

MS. HANSEN: But some of the unique issues of the pressures for this particular market, as compared to the market as a whole, is that factored in and considered in some unique way?

MR. GLASS: I guess I'm not quite following your question. In that area this will reflect the wages paid to all RNs, whether the RNs worked -- the BLS -- whether the RNs work in a hospital, in a doctor's office, in a SNF, in a home health agency, or whatever. So all that will be in there.

So if that particular area has a very tight market for RNs, then presumably all those wages will be lifted. So peculiar market conditions will be reflected.

What we're measuring is the relative wages of RNs in that market to RNs in other markets.

MR. HACKBARTH: Before I go to Bill, I just want to clarify where we stand in terms of the process on this. As you know, there was no paper in your notebook on this. I just want to be clear with the Commissioners and with the public audience that we are not at the point of reaching a conclusion on this work. Nobody is being asked to embrace this approach definitively as an alternative but rather we're more seeing guidance. Is this a tree that we want to bark up for a while and potentially come back with a recommendation next year. Is that right, David?

MR. GLASS: What we've been doing so far is just

to explore whether, in fact, this is even possible to do and then what the results look like at first glance and see if it seems like a practical feasible approach that might have some benefit. That's really where we are now. and then, as I say, we want to look at smoothing and we want to look at how this would work for other sectors.

MR. HACKBARTH: Okay, Bill.

DR. SCANLON: While I'm generally supportive, I guess I'm wondering, the problems we're trying to fix are reducing the burden on hospitals in terms of providing information, expanding beyond the hospital because we're concerned that the hospital may not be representative of the labor market. But there's a question of if all the hospitals in an area are having to pay higher wages then the rest of the labor market and in other markets they don't, which is the right measure? There's that difficulty.

You said there's a high correlation between the old measure and the new measure. And I guess I would be interested in knowing for the outliers what do we know about the outliers? Is there anything systematic about outliers? Because that might tell us something about -- that there are differences in market dynamics that may make that -- may

play a factor in terms of which we prefer.

I think the idea that -- is there an ease here to deal with occupation that is not -- I mean, this idea that we're having difficulty getting occupational adjustments into the wage index is troubling, given how long we've known that this has been a problem. And so it there's a fast way of resolving that, certainly we should be thinking about that. So the advantages with respect to occupation here argue in favor of the new method.

You just raised this last point, which to me is probably the most important two steps, which are on page three, which is what about the variations that exist within MSAs? That's a potential serious concern because some of these MSAs get extremely large and it's hard to think of them as single labor markets, though they may not be so far apart that there's a need for adjustment.

Secondly, our reclassifications are largely because of the cliffs. You move across a boundary and you say that you get everybody from the other labor market but maybe you don't. And I think we need to think about that smoothing process.

I guess the last part I would say would be the

issue of not only the variation within MSAs but the variation within the balance of the state. When GAO did some of this work a number of years ago, they distinguished between the larger towns, the medium-sized and then the other rural. A lot of that may have gone away in terms of being an issue because of the critical access hospitals, but still it may be that the balance of the state is not a homogeneous market or have the same wage levels, even though it's not a single market.

MR. GLASS: I think that's correct and that last problem, depending on how the smoothing worked out, might still remain. It also raises the issue of since they've taken critical access hospitals out of the data pool under the current system there's very little data to set that rate. Whereas in this system you'd have whatever BLS finds.

DR. REISCHAUER: A couple of questions. You talked about doing this for the various health sectors and I was wondering what kind of detail BLS had below hospitals? Is nursing homes a category and home health agencies?

MR. GLASS: Actually yes, health agencies and nursing facilities, which would not be SNFs per se, but the entire nursing facility is a category also. We're thinking

that we might jigger around some of those occupations within that that we know are more heavily used in a SNF than in the nursing facility, for example, or aren't used for Medicare home health patients and are used for other home health patients.

We'd have to play around. That's why we haven't done that one yet. We'd have to play around with that a little bit.

But yes, SNFs and home health exist, I don't think -- long-term care hospitals clearly is not a separate category.

DR. REISCHAUER: You said that there was a high correlation between the new measure and the old measure. But have you done any analysis of the fraction of hospitals that would have their index changed by more than 10 percent or more than 20 percent?

MR. GLASS: We don't have numbers on that yet. We've been working on that but we don't have numbers on that yet. As I said, the big differences -- the biggest systematic difference is when you get the hospitals with very high wage index values under the current system.

DR. REISCHAUER: The final issue, we're talking

about wages here and that's fine if wages are correlated with the other components of compensation. But my guess is they're not and it's systematic across employers. And here I'm talking about working conditions, fringe benefits, which might actually go in the opposite direction. Large institutions like hospitals probably have good fringe benefits, might have bad working conditions relative to an RN working in a doctor's office.

Are we collecting any kind of information to figure out total compensation just in one or two areas? And how it's broken down by institution type or employer, how much is wages, how much is fringe benefits?

MR. GLASS: The current system is wages and benefits, the current one. The average wage data they collect --

DR. REISCHAUER: The BLS is not.

MR. GLASS: The BLS is not. The BLS is strictly wages and doesn't include like self-employed, for example. Jeff, we were looking at this question of whether we could differentiate between strict wages and benefits using the hospital data and see if there's any pattern there, to see if it's a geographic pattern with wage index or what. So

we're looking into but I doubt that we'll get a really definitive answer.

DR. KANE: Just a question. How much variability is there in the occupational mix if you take a national average? Is there a wide liability in like 26 percent nurses versus 45 percent nurses? And then the second related question is if there is a lot of variability in the distribution of that in the proportions, why would you take the national average and not something like the most efficient or the best use of occupational mix? If you're going to go all the way you might as well go all the way.

I don't how much variability there is in these occupational categories across the hospital.

MR. GLASS: I guess I'm not quite following. The data we have is that at the national level we have what the occupational mix is.

DR. KANE: But by hospital, how much would a hospital deviate from that national average mix?

MR. GLASS: We don't know that. I suppose CMS's new survey may help answer that. The old one people were quite suspect of.

DR. STENSLAND: We looked at the old data and that

did imply a fair amount of variation in terms of who uses RNs and who uses LPNs. But there's also some question that CMS wasn't so comfortable with that data, so we don't want to place too much weight on it.

DR. KANE: Would this in any way create the incentives for the mix in the future, how the hospitals -- what kind of labor mix they use? If you put a national average on there?

DR. REISCHAUER: Whatever you use, we'll pay for it; right?

MR. GLASS: Right now, yes. If you use the new approach, they'll have a wage index that relates to the national.

DR. KANE: That they can try to game.

MR. GLASS: They can't game it. It is what it is. But if they want to --

DR. KANE: They can game it by getting cheaper labor.

MR. GLASS: They'd have the correct incentive to optimize their mix.

DR. KANE: To go lower on their occupational mix.

MR. GLASS: Whatever incentive they have to lower

their costs, which they have now, of course.

MS. BURKE: Nancy raises though an interesting question. There is sort of an underlying discussion going on as to what the right occupational mix is, given the nature of the kinds of patients that you serve, and whether we want to encourage -- the whole question of RNs to patients, depending on the nature of the hospital.

There is an interesting question and whether or not we either mask that by simply saying do what you have to do and this is the average, or whether we want to encourage certain kinds of behaviors is, I think, an interesting question. Because there is wide variation for a variety of reasons. Certainly patient mix is one. The other might be locality.

We have, for years, tolerated lower rates of RNs to patient mix in certain areas of the country where recruitment has been very challenged and they are predominantly staffed by non-RNs. So there are big variances for lots of different reasons.

DR. KANE: So wouldn't you want to maybe do a quality adjusted labor mix or something? I don't know if that's even possible.

MR. GLASS: I think you'd prefer to look at the outputs rather than the inputs. If you were looking at quality you'd look at the output, not what mix they choose to use to get to it.

DR. KANE: You're going to do a national average mix of labor and perhaps you might want to base the mix on hospitals that have the highest quality or something. I'm just trying to get at how do you get at that? I don't even know.

MR. GLASS: Remember, this is just to get the relatively wages between areas, the relative underlying wages between areas. So which mix you chose, if you were reflecting it in all areas, I'm not sure that it would drive anyone to do one thing or the other. It wouldn't drive a hospital to hire one way or the other.

MR. HACKBARTH: The basic incentive would be the same as under the current system, which is to use the lowest cost mix of labor that you can, consistent with a quality product, with you defining the quality product that you want to produce right now. That incentive stays the same under either.

Other questions on this?

DR. SCANLON: I was going to say exactly the same thing Glenn did. Remember, what we're talking about here is taking an average for an area, which can be as big as an MSA and can maybe have 15 or 20 hospitals in it, and comparing that to the national average. So the individual hospital in the MSA has the incentive to be as inexpensive as possible, assuming that they're not thinking they're going to drive their wage index.

The occupational issue I think was more important in the past when we actually had to have a lot more rural hospitals that we were paying under the PPS because we had those hospitals which may be somewhat less intensive than some of the major urban area hospitals and that there was a bigger difference between the wage index because in the urban area hospitals we had more high-tech people, even beyond nurses, other kinds of ancillary personnel.

And again, as we've taken more of the rural hospitals out, that's become less of an issue. But why leave it as a lingering issue at all? Fix it by setting the occupational mix in setting weights for the overall index.

DR. MILLER: The only other thing, and this is just to think about, and we're still thinking about all of

this.

To your point about shouldn't we be encouraging the quality here as whether you want to actually pay that on the other end of the process, which is if you have good quality outcomes then I'll pay at that point, as opposed to trying to build it into the wage index. That would be the only other...

MR. HACKBARTH: I think that was David's point about paying for the outcome.

Thank you.

Next is physician geographic payment areas.

DR. ZABINSKI: In the Medicare program most physician services are paid under the physician fee schedule which has payment rates for over 7,000 services. These rates are adjusted for geographic differences and input costs.

In particular, under the physician fee schedule, CMS has created 89 payment localities. Each of these localities has its own set of geographic practice cost indexes or GPCIs that CMS uses to adjust the payments for the geographic difference.

Recently, the California Medical Association, the

CMA, has raised question about whether the structure of the payment localities causes the GPCIs to inaccurately reflect local costs of care, which can cause underpayments in some areas and overpayments in other areas, creating inequities among physicians.

The primary argument against localities is based on two points. First, they are often too large to account for geographic differences in the costs of care. And second, they are often based on geographic entities that were established as long ago as 1966 and consequently ignore changes in economic and demographic conditions that have occurred over the last four decades.

Because of the issues raised about the localities and because they have not been updated since 1996 we believe that they should be evaluated alongside alternative definitions. Today I'll discuss two alternatives.

One of these alternatives is what we'll refer to as the locality option and it was largely developed by the CMA. This alternative begins with the existing localities and then, within each locality, you calculate an index of local costs of care, a geographic adjustment factor or GAF for each of the counties in the locality. Then in each

locality you compare the GAF of the highest cost county to the average GAF of the other lower cost counties in the locality. Then if the GAF of the lowest cost county exceeds the average of the other counties by some preset threshold -- 5 percent is often used -- that highest cost county becomes a separate locality.

Then from there you go through an iterative method where in each step you compare the costs or the GAF of the highest cost remaining county to the average GAF of the other remaining lower cost counties. This iterative procedure stops at a point where the GAF of the highest cost remaining county does not exceed the average GAF of the other remaining lower cost counties by the preset threshold.

Basically in summary, the idea here is that within each locality if a county distinguishes itself as being relatively high cost to the other counties it becomes a separate locality on its own. And the other counties that do not distinguish themselves as high cost are collected into a single new locality.

The other alternative we looked at is called the MSA option. And this option is very similar to the locality option I just discussed, but a key difference between the

two is the starting point.

In particular, under the MSA option you eliminate all the existing localities and you start from scratch. Then in each state you collect the urban counties into metropolitan statistical areas or MSAs and the other remaining non-urban counties into a rest of state non-urban area. Then you calculate a GAF for each MSA and for the rest of state area. And then in each state you compare the GAF of the highest cost MSA to the average GAF of the other areas in the state. If the highest cost MSA exceeds the average of the other areas by the preset threshold, that highest cost MSA becomes a distinct and separate new locality.

Then you go once again through an iterative method where in each step you compare the GAF of the highest cost remaining MSA to the average GAF of the other remaining lower cost areas and you stop at the point where the GAF of the highest cost remaining MSA does not exceed the average of the other area by the preset threshold.

In summary, in any MSA that distinguishes itself by being high cost becomes its own locality. Those areas that are not high cost are collected into the rest of state

area.

Then, using a 5 percent threshold to identify relatively high cost area, we found that both the locality and the MSA options would increase the number of localities over what we currently have. As I mentioned earlier, we currently have 89 localities. The locality option would increase the number to 186 and most of these new localities would be single counties. The MSA option would increase the number of localities to 119 and most of these localities would have more than one county because MSAs are typically collections of multiple counties.

An issue to consider in any reconfiguration of payment localities is this: right now, under the existing localities, 34 states are what are called statewide localities meaning that have a single GAF or payment rate for the entire state. Two points to realize here is that the physician community chose this avenue in many these states and also that these states seem content with their current situation.

So this might raise the question of should the statewide localities be maintained and excluded from any reconfiguration of payment localities?

On the one hand, including those statewide localities in a reconfiguration would result in more accurate payments at the local level and consequently less incentive for physicians to avoid underpaid areas. Also, you would have a consistent method across all states for defining payment localities.

On the other hand, excluding the statewide localities from a reconfiguration would maintain continuity in the states that have decided to have equal rates between their urban and rural areas. Making changes in these states could be disruptive to existing position/patient relationships.

Also, excluding the statewide localities from reconfiguration would help minimize the administrative burden on CMS. For example, as I just mentioned, both the locality and the MSA options would increase the number of localities over what we currently have. This would give physicians greater opportunity to set up offices in more than one locality and then physicians could then game the system by submitting all their bills from their office that is located in the locality with the highest GAF. CMS would have to expend resources to counteract such gaming.

Then we went on and we applied both the locality and the MSA options using a 5 percent threshold to each state and found some interesting effects of both options. To start, we realize that both options are designed to be budget neutral nationally. But we also found that both options would be budget neutral within each state, meaning that the payments under the physician fee schedule going to each state would not change. But within states both options would shift money from some areas to other areas.

A second effect of both these options is that it would improve how accurately the locality GAFs, and consequently local payments, match local costs of providing care. Paying accurately at the local level can be important because it can reduce incentives for physicians to avoid underpaid areas.

Finally, both options would affect the differences in GAFs and payment rates between adjacent counties. Avoiding such large differences between adjacent counties can prevent perceptions of inequity between providers who might be in close proximity geographically but have very different payments because they are in different payment localities.

Then we went on and we used both the payment accuracy at the county level and the differences in GAF between adjacent counties as criteria for evaluating the MSA and the locality options as well as the existing payment localities. In particular, on this diagram we show how the locality option, the MSA option and the current localities would fare under those two criteria.

In the first column, it reflects the average across counties of the absolute difference between county locality GAFs and the county GAFs. In other words, this column shows the average difference between county payments and county costs. The smaller the number, the more accurately county payments match county costs on average. The average difference between county payments and county costs would be about 1.5 percent under the locality option, 2 percent under the MSA option and is currently 2.2 percent under the existing localities.

In the second column, we show the average absolute difference in GAFs between adjacent counties. That is it indicates the average difference in payment rates between adjacent counties. Smaller numbers indicate smaller differences on average. Here we see that the average

difference in payment rates among adjacent counties would be about 2 percent under the locality option, 1.4 percent under the MSA option, and is currently about 1.8 percent under the existing localities.

A key point to draw from these first two columns is that the results in those two columns show only small differences between what we would get under the locality and the MSA options versus what we currently have with the current localities. The purpose of the third column is to show why neither the MSA nor the locality option is much different from the existing localities.

In particular, the third column shows the average among counties of the change in payments from current policy to the payments that would occur under the locality and the MSA options. Smaller numbers indicate smaller changes. In particular, the average change in payments from current levels would be small under both options. It would average about 1 percent under the locality option and about 1.6 percent under the MSA options.

On the next three slides we show the distributions of the three measures on this table. Here we show the distribution among counties of the difference between county

payments and county costs under the locality and the MSA options. The two main points here are that first, under both options the difference between payments and costs is less than 2 percent for a majority of counties. In particular, this occurs 64 percent of the time under the locality option and 56 percent of the times under the MSA option.

Second, only a small percentage of counties would have large differences between payments and costs of 5 percent or more. That would occur 1.7 percent of the time under the locality option and 4.9 percent of the time under the MSA option.

The next diagram shows the distribution among counties of the difference in payment rates between adjacent counties under the locality and the MSA options. The main point here is that there is a large spike at zero, meaning that under both options the majority of counties have no difference in payment rates with their adjacent counties. This would occur 55 percent of the time under the locality auction and 74 percent of the time under the MSA option.

Finally, on this diagram, we show the distribution among counties of the change in payments from current levels

to payments that that would occur under the locality and the MSA options. The two main points here are first, that under both options the change in payments from current levels would be less than 2 percent for most counties. That is, that would happen about 82 percent of the time under the locality option and 67 percent of the time under the MSA option.

Also, only a small percentage of counties would have a large change in payments of 5 percent or more. Under both the MSA and the locality options, that would occur about 5.3 percent of the time.

To conclude this discussion, I'd like to consider two issues. The first is a question. Is a nationwide change in payment localities worth the costs of administrative resources that would be necessary and the potential disruption in services that could occur? I ask this because, as we just saw, the locality and the MSA options would both have small effects on the payments going to most counties.

Second, even though most counties would have small changes in payments, large payment errors are occurring in a few counties and these counties would see substantial

changes in payments under the locality and the MSA options.

Therefore, bringing these two issues together, because most counties would see small changes but a few would have large changes under reconfigured localities, perhaps the Commission would like to consider a method that addresses the situation of these counties that are facing large payment inaccuracies.

And now I turn things over to the Commission for discussion. In particular, we're looking for guidance on whether we should continue our analysis of this issue. And if so, advice on how we should proceed.

DR. REISCHAUER: Two observations. One is you keep referring to these changes as small, 1 or 2 percent. But let's remember, that's what the average update is or has been for the last four years. So from the perspective of physicians, it might not be so small.

The second observation is I wonder if we're opening up Pandora's box here with these thresholds. You say well, you look at the counties in this area and if you're 5 percent above, we regard that as justification for creating a new area. But we aren't doing it at the bottom. What if there's a county at the bottom? Or what if, among

all these counties, there's a gap somewhere between one group that's 5 percent lower than the next group up? We're providing a justification for a 5 percent differential that says you're different and we'll treat you differently. But we're only doing it for that differential when it occurs at the very top.

I think that's inviting problems in the future.

MR. HACKBARTH: So tell me what the alternative is to using some threshold?

DR. REISCHAUER: What we're doing right now, leave it alone. Most people find it's okay.

DR. CROSSON: I'm going to beg some indulgence here because I'm going to present a perspective from the left coast, which often requires indulgence in these here parts.

This actually has been a significant problem in California. It has been an issue that has created a lot of difficulty for the medical association. Obviously that's why they've been trying to find a solution. Maybe it shouldn't have, but it has.

There are in fact, as Bob mentioned, some counties where the physicians are receiving substantially less for

providing the same services. Some of those are really quite adjacent to other parts, particularly in the Bay Area. There are 10 percent differences.

In the current environment, and the problems created by the SGR, it just seems to have created more sensitivity than it might in an environment where the updates were more like the MEI. So when the food gets scarce, the table manners deteriorate, or something like that

So it is a real problem.

DR. REISCHAUER: What's the problem you're referring to? You have Marin County, then what's next to it, Humboldt?

DR. CROSSON: Hot tubs are very expensive.

DR. REISCHAUER: It's the gap going that way.

DR. CROSSON: You mean which counties?

DR. REISCHAUER: Isn't it a balance of the state problem which he's pointing out? How do you drift out of the San Francisco area into the more rural part of California? There's a cliff there you're talking about.

DR. CROSSON: For example, the difference between Santa Cruz County, which abuts with Santa Clara County where

I am, is about a 10 percent difference. So we actually have one medical group in Palo Alto, Palo Alto Medical Group, that has a branch in Santa Cruz which is about 35 minutes away. There's a 10 percent difference in the physician payment there.

DR. REISCHAUER: But are you in the same group or not? You aren't?

DR. CROSSON: Those are two different localities.

DR. REISCHAUER: But I don't how this is going to help that.

DR. CROSSON: Can I get on with it?

DR. REISCHAUER: I'm sorry, I didn't give you the indulgence that you asked for. I apologize.

[Laughter.]

DR. ZABINSKI: What would happen in this is that Santa Cruz would get carved out from what's called the rest of state right now and they would be carved out and their payment rates would go up by about 10 percent.

DR. CROSSON: But on a budget neutral basis.

DR. REISCHAUER: You're saying that Santa Cruz is 10 percent under where it should be.

DR. CROSSON: That's correct.

DR. REISCHAUER: As opposed to there's a 10 percent difference between these two. Those are two different facts.

MR. BERTKO: No, it's the same.

DR. CROSSON: As I was saying, so it seems to me -- and the next question is, as was part up, is this important enough to fix? It depends on the eye of the beholder. Overall, compared with some of the problems we face here, it's small. For the individuals and the dynamics that are taking place in that community -- and I think probably a few others in the United States -- it's not small.

There is a logic to the proposal that is to use the localities, and to use the 5 percent threshold for the ones that are at the top because that's the way the formula was created in the first place. That's how CMS created the localities in the first place.

So to do that and to, in a sense, open it up again for perceived problem areas is simply to use as the same mechanism that was used in the first place, not to invent a new one.

Or looking at it another way, you could say the

artificiality here was to freeze it and never change it, based on the calculations that were done in the past. So I think there's an argument there.

There's also an argument derived from the data that to do it that way would have less disruptive impact than for example to do the MSA model. So I think there's an argument there.

I think there's an argument to focus the fix initially on the 16 states that are multiple locality states because that appears to be where the greatest differential is, which is why there are multiple locality states in the first place. As opposed to necessarily opening it up immediately to all 50 states because, as was pointed out in the presentation, the majority of those states appear to be homogeneous and don't have the concerns that have been brought forward by -- as some would say -- the least homogeneous state we have in the United States.

I think the administrative resource issue is real and that is how many things do we want to adjust and change? I think that can be dealt with by doing this only periodically. There's no reason to do this every year. The dynamics which create larger expenses in different

geographic areas proceed slowly, not quickly.

So this adjustment, for example, could be made at one time soon, could be focused initially on the 16 multi-locality states. And then, for example, three years later or six years later that the next or the next to the next cycle of readjusting that goes on, the fix could be created again or states medical societies in this case could be given the option to propose a different way of doing it. Which changes the political dynamics within the association compared with the problem that we have now, which is they can't agree on winners and losers.

And in fact, in three or six years the issue of opening it up to all 50 states could be readdressed. So I'm actually suggesting a stepwise approach as a set of ideas that try to solve the problem and minimize the stated and real concerns.

I'm done.

DR. REISCHAUER: I'm being polite.

MR. SMITH: Jay, is what's driving the concern -- you talked about the Santa Clara folks with a Santa Cruz office. Santa Cruz, I assume is in the balance of state and Santa Clara is in the SMSA?

DR. CROSSON: Yes, that's correct.

MR. SMITH: So is the different Santa Cruz costs or Santa Cruz payments? What is it that's got people aggravated? If Santa Cruz costs look more like balance of state costs, then why should the docs get Palo Alto money?

So it depends a little bit on how this issue shakes out in terms of real costs, not simply propinquity to a higher or lower cost place.

DR. CROSSON: My understanding of it is that the Santa Cruz situation was one thing in 1996, I believe it was when it was set. And now, in relative terms, it has changed over that time.

MR. SMITH: By Santa Cruz has gotten relatively more expensive than the rest of the state.

DR. CROSSON: I'm sorry, costs. And the same formula, the same process for determining whether a locality was put into the multiple locality larger group -- that was applied in 1996, if that was applied now then Santa Cruz, for the same reason, would have its own separate locality. But it was frozen and not updated.

DR. STOWERS: I'm going to stay a little bit out of the California question? The thing I'd like to talk

about a little bit would be whether we should include or exclude the statewides. Having been very involved in that at the time when we went around the nation and tried to get this statewide thing approved first and then implemented. We've got to remember the initial reason for that was the fact that there was tremendous payment between the rural and the urban physicians. And my payment, for example, was 30-some percent less for an office call in the rural than what my buddy was that was in Oklahoma City, and so forth.

What the physicians came together and found was there was very minimal change in those that were in the higher cost or urban areas and those type states that are very much rural to raise and to bring up an equal payment for those that were out in a rural area. And the state was facing tremendous problems of getting physicians out into the rural areas.

Since that time the rural implementation or supply of physicians in the rural counties is tremendously increased. A big part of that was this.

So by going to a more accurate payment, we would not solve the problem of getting more physicians into the needed areas. As the chapter kind of inferred, it would

actually do exactly the opposite and turn that whole process upside down again.

But the main thing that sold that argument that still exists today, and we don't go into it in this chapter and I think maybe we should before we go forward, is that there's a lot of problems in the way that this whole expense thing is calculated in the first place. And I think until those problems are corrected we're going forward with kind of funny numbers.

For example, what's local cost and what's national costs? I don't care if you're out in a rural area, if you buy your computers and those kind of systems, and especially as we go into high-tech areas of implementing IT and offices and that sort of thing, that's still figured on a local level.

So I'm just giving you one example of problems that are in there.

MR. HACKBARTH: I'm sure you're right that there are problems in the calculation. But let me just set that aside for a second.

If you have a system based on the principle that we ought to adjust for geographic differences and practice

costs and the payments ought to be adjusted correspondingly, it seems to me that you buy into periodic adjustments of that system.

Even though I think you're right, it could mean that in some circumstances, some states, it would work against the goal of encouraging physicians to practice --

DR. STOWERS: In fact, in the majority of the states in the nation.

MR. HACKBARTH: If that's the basic principle that your system is designed on, to say we're going to freeze it in perpetuity based on a snapshot that was taken in 19-whatever, just doesn't seem reasonable.

DR. STOWERS: I'm speaking to agree with Jay that I think that we should leave alone those that are agreeing to a statewide concept to meet the mission of that state to serve their rural areas. But I think it makes absolutely perfect sense in those where you're going to recalculate to do it with more current data and to update it and that kind of thing.

But I don't think the two necessarily have to go together. If the state believes in the purpose of a statewide, then let them do it. But if in fact a state that

has great variance needs to recalculate and has a different distribution of physicians, then it doesn't make sense to be on 1996 data and that kind of thing.

There's another number in here that would tremendously change things is that somehow in the original figuring of geographic costs, physician work was left in as part of the geographic -- this is not just based on practice expense. That geographic factor also applies to physician work.

So it makes sense to me that if we recalculated this and looked at it again just based on the practice expense, but right now there's geographic adjustments for work, practice expense and for the malpractice or professional liability. That is another number that a lot of people who calculate it say will change these numbers a lot.

It really doesn't make sense that somebody working in a rural area seeing the same patient, doing that same work piece, would be paid differently than somebody in a different setting. Although if in fact the state chooses, I think there should be a different geographic practice expense change in there.

So I think there is just things in that that really need to be looked at. With the minimal changes occurring here, especially with the statewide, I'm not sure it's time to move with it. That's all I'm saying.

DR. NELSON: We've always had, since I've been on the Commission, we've said that the payments should try and accurately reflect the cost of providing the care. And if there are reasons for giving additional payments to underserved areas, we ought to deal with that directly by having payments for physicians in underserved areas, as we do. If that isn't enough, we ought to make it more. That's a different issue.

I can't see why not to support this. The idea of well, CMS has got a lot of work to do, well that doesn't negate the principle that we've adhered to in the past. We tell them to do a lot of work on a lot of things and they do as much as they can.

So I'm with Jay. And I'm not with it just to solve California's problems. The bigger issue is to have payments accurately reflect the local cost of providing care to the degree that that's possible.

DR. MILSTEIN: Again holding California aside, I

want to second Alan's point. We have recommended adjustments in the payment system to improve its fairness for differentials and unfairness as we've calculated far smaller than these 10 to 15 percent levels of unfairness that we've uncovered in some areas.

So I think if you use our precedent of what degree of unfairness we previously used as a threshold for action, such as our recommendation to refine the hospital payment system, they have been at far lower levels of percentage imputed unfairness than we're looking at in some of the geographic areas described here.

MS. BURKE: I don't disagree with the ultimate goal of trying to be as accurate as we can and tracking as best we can a payment system that reflects the actual costs of doing business. I am reminded a bit of the debate that have taken place historically though around MSAs. And any time you begin to geographically break things up, people suddenly yearn to be in another county. We have lots of examples of statutes that moved people across lines to take advantage of difference in payment rates.

I am interested in the issue that Ray has raised and that is to try and get a better understanding of how

widespread this problem is and whether there is a way to get to a solution that makes sense without reconfiguring the entire system.

I'm also mindful of Bob's comment, that while 1 percent seems small, it isn't small to the folks at the 1 percent. And I am interested in the charts that show, in some cases, there's zero or less but in some cases there's 5 and 10 percent. I can already imagine there are folks in the back of the room that are trying to figure out that map. And that is who's in which of those columns, in terms of what the impact would be.

I think it would be important to understand that, that is how widely distributed this problem is. As I understand it, as I recall from the paper, there are 20-something statewides currently. 26? I can't remember.

DR. STOWERS: 34.

MS. BURKE: 34 current statewides. And so the question is, as you begin to move around, do they rethink their position? Don't know that, whether anyone's asked that question or whether that would be a question that would need to be asked.

But I think that Dan has laid out for us the whole

series of questions and a couple of options that are certainly worth considering. And I think there should be a goal of trying to make sense out of what, in fact, is reality in today's market. These are quite dated.

But I would want to understand more clearly what the distributional impact might be, how widespread this problem is today. I know it can't possibly simply be California but I would interested in understanding how much dislocation there currently is. I think the goal ought to be to try to make more sense out of it but it is a quagmire once you get into it, once you start moving things around.

And I'm assuming, Dan, and I'm assuming in the course of this work that the expectation is whatever change would be made would be neutral to the area? Or are you talking about redistributing across the entire system?

For example, if you leave the states intact, those that have chosen to be statewide, and you start adjusting and fix the problems -- I mean we're not fixing the problems where people are being overpaid potentially. If you assume this is a zero sum game, you're going to be moving money around.

The question is you're moving around what area?

Is it the presumption that you only move it within a stat? Do you move it across the system so that you're taking from Mississippi to take care of Texas's problems? Or whomever it is that happens to play out.

What is the expectation in any of the scenarios that you've laid out?

DR. ZABINSKI: As it turned out, I don't want to say this was almost an accident, but both these alternatives I talked about are budget neutral within each state. So each state, the payments going to each state would not change from what they currently get. But there would be shifting, of course, within states.

MS. BURKE: And that's because we would construct it in that way or that's just the way the analysis worked out?

DR. ZABINSKI: Here's my take on how it happened is that the current localities are sort of self-contained. Each state has divied up into each locality. These localities never cross state lines. And both these options sort of do the same thing. They just take each state -- I mean, the locality option just takes the existing localities and draws out some high cost areas and leaves the rest of

them.

DR. REISCHAUER: Then you recalculate the GPCI for what's remaining there in locality and it goes down. So Santa Clara goes up and the balance of that locality goes down.

MS. BURKE: That is a policy position we're taking is that whatever we do --

DR. REISCHAUER: That's the way it works.

MS. BURKE: I'm just asking the question. That's the way we'd structure it? So it would be within the state. I just wanted to clarify that.

DR. MILLER: I guess I just want to clarify that you're saying a policy position we take. Generally the way people have thought about reconfiguring these localities and adjust them a little bit or work with the MSA, the arithmetic just basically falls that way. It's not like we set out and set up --

MS. BURKE: No, I understand. I understand. That's why I was asking the question as to what the impact would be, because any time you get into a redistribution, there are inevitably winners and losers. And so the question is how widely distributed are those wins and

losses? And the question is they are within that small venue.

But again, I think we'd want to understand more clearly, I mean to look at these things at a distance and see sort of the movement around of 1 percent, 2 percent, becomes much more real when you actually run these numbers out and you look at which counties are actually affected. And people become much more engaged in that when that becomes the case.

So again, I think we'd want to understand a little more clearly and query whether or not it is a solution that can be applied only to the areas that are identified as problems or whether this is something that we would want to put through the entire system. I think that Ray raises a good point.

MR. HACKBARTH: I think we are well short of a consensus on this, so I think the chapter that we write we need to be very careful not to imply that there is agreement on one option or the other. It has to be very much on the one hand, on the other hand.

My sense of this is that the "problem" is not widespread. It is relatively localized, which is good news.

All other things being equal I'd just as soon not have the whole system overturned and redone, although I guess that is sensitive to what you define as the threshold of a problem and the analysis that's been done here used 5 percent. I don't know why 5 percent is better than some other number.

DR. REISCHAUER: And only at the top.

MR. HACKBARTH: And only at the top.

DR. REISCHAUER: So by definition it's going to be small.

MR. HACKBARTH: So the basic issue here is if we have a system that adjusts for geographic differences, to whom does the right to fair payment belong? Is it a state association right? Or is it the right of the individual practitioner being paid under the system?

I think our general policy in Medicare is it's the right of the individual practitioner to fair payment. And so we need to set some threshold. We need to periodically readjust the system to reflect changes in underlying practice costs. And I don't think a state association or anybody else ought to be able to override that and say no, we want a different distributive policy.

To be very specific, I'm agreeing with Alan. If

we want to increase payments for rural areas because of shortage issues, we've got mechanisms in place to do that and we can use those and increase those payments more.

But to say that we're going to stop geographic adjustment as a way to accomplish that goal, I think is not fair, it's not consistent with our basic payment systems in Medicare.

DR. STOWERS: I may have misspoken there a little bit. It's not so much that it was just simply being used as a mechanism to get payments out. I think that this would have never happened in those states, the 34 or whatever, if in fact they felt that the system adequately represented the expenses in the lower cost areas. And those problems that were recognized nationwide, the distribution of what you have to acquire nationally and all of those things have never been corrected.

So what I'm saying going forward with this kind of thing, without having an accurate way to measure practice expenses in those areas, could do a lot more damage than could do good. I'm not against going back to it but what happened at that time, there was a policy decision made in Washington that rather than to go back and write the whole

way of calculating the thing, because everybody in the nation at that point agreed that the way that the practice expense was being figured in those areas was very, very inaccurate. So what do we do? We'll just allow the states to go to a statewide thing.

So I'm saying going ahead without now going back to Congress and fixing those other problems doesn't make sense. If we go that route and recommend doing that and then go to an accurate way of -- because I think you're going to find the practice expenses in those areas to be considerably higher than what was first believed to do just because of the old formulas that go back into the '80s that have never been changed.

That was my point. It was just the only mechanism at that time to fix a problem with the way it was calculated.

MS. BURKE: Following on it, it raises an interesting question. If in fact we take the position that we believe that there ought to be more accuracy in payment and that we ought to, by trying to solve this problem, move in that direction, one might wonder why we wouldn't then go back to those states that have chosen to essentially blur

those lines and take a position that in fact the answer is essentially a statewide. Why would they not want to come back and say well, if you've got a better way of figuring out things that are much more geographically specific, why aren't we back in the game? What makes us different?

It would be one thing to say let's fix the problem but it does ultimately raise the question if the presumption is that the statewide -- which was the blurring -- was to avoid having to deal with a problem they couldn't deal with, if you now have a way to deal with it because you're able to be more accurate, why wouldn't those same states come back and say we want to be back in play? Why are you leaving us essentially with this system that is, in fact, not as accurate as you're now able to do?

It would be difficult to explain, I think.

DR. REISCHAUER: Because they might legitimately want to pursue this other social goal, which is the redistribution of medical resources towards underserved areas. And they realize that the federal system is not very responsive to that need.

We have two conflicting objectives here, both of which are worthy.

MS. BURKE: Who's decision is that? To Glenn's point, whose decision is that to make? Is that a state society's decision?

MR. HACKBARTH: Potentially what you could have is a system that says the basic rule is that the right to fair payment belongs to the practitioner. And so when a locality exceeds a certain threshold, gets out of line by whatever the percentage is, we reconfigure. So do you take Marin County out and that means that all the lower cost counties in the locality are going to go down, just the arithmetic is going to work that way?

Now if California wants to come in and can develop consensus, including the physicians in Marin County, for an alternative financing mechanism that may be more compatible with their goals, they could do that. But Marin gets fixed. They have a right to get fixed. So if you can't reach agreement, Marin still gets fixed. But if you can reach agreement on an alternative statewide policy, CMS respects that.

MR. SMITH: [off microphone.] Why wouldn't that logically lead any practitioner to do that? If the practitioner's got a right to fair payment and an accurate

system provides them with that fair payment but her colleagues decide that they'd rather send the money a little bit further north, how do you square your principle which I think you've articulated well with not paying fairly?

MR. HACKBARTH: You're raising an important point about how you would operationalize all of this. Is it every individual practitioner? Is it a majority of the practitioners in Marin County? Point well taken.

Personally, I feel that the basic decision role needs to be fair payment for providers. I'm just trying to think imaginatively about a way that we could allow by consensus some alternative policy be pursued within a state. But that may not be workable.

Mar, do you have any --

DR. MILLER: I knew it was going to come to this.

MR. HACKBARTH: I'm trying to give you a lots of time.

DR. MILLER: I know and I've been using it, but I have a phone call so I have to step out. I can't answer the question.

We're left with the dilemma of trying to write the chapter here. I have been trying to think about this as you

were going around. There are a range of options that have been talked about here, including one early on of maybe you just leave it alone. Because if these principles are so much in conflict and there is not a clear way to break out, it does maybe mean that there is that.

There's a couple of things here. The chapter could try and set up this internal conflict, what is the guiding principle in this, and then try and talk about the different options because the different options basically fall along how you feel about these different principles. So you could have sort of an automatic adjustment if your principle is that every physician should be dealt with as accurately as possible. But if your principle is that the state has an overriding social goal, you could talk about allowing the state to come in and say, actually we don't want this to happen. We want it to happen this way, as long as there's a consensus in the state -- however defined.

The chapter could just simply go through that and in a very noncommittal way say these are the different ways you could think about it. Because that's the only way I can see drawing this together because there is no clear take on it.

The other thing is, if we think that there is still work to be thought about, if there's not enough consensus as to whether we're really ready to go forward with this.

MS. THOMAS: We had not intended for this to be a June report chapter, not wanting to roll this out in April and have this be your first time through. So we can return to it if you decide.

DR. MILLER: Maybe that's what we're doing here. I guess I should have taken that call. Oh, it was Sarah saying don't say what you're about to say. It happens a lot.

[Laughter.]

DR. MILLER: So I guess if this is not going to going into June, I think we can try and take another pass at some of these sets of questions and then bring it back to you and see if we cannot come to a consensus at least we can capture the degree of disagreement fairly among the commissioners. Is that fair?

DR. REISCHAUER: Is all the data collected on a county basis?

DR. MILLER: Yes.

DR. ZABINSKI: Yes.

DR. REISCHAUER: Because supposedly these are groups of counties that have homogeneous costs and there's really no reason why they have to be contiguous at all. And you could say there's going to be six categories in California and we're grouping these 22 counties that have costs around 84 together and these 16 counties that have costs around 97 together and treat them that way rather than the way we've done it in the past.

It might be that Santa Clara and Santa Cruz and Marin are one group.

MS. BURKE: Mark, in pulling that together I would be interested in seeing the list of states that are currently statewide. It would be interesting to understand.

DR. ZABINSKI: Figure 4 in your mailing material has a map. Any state that's one solid color is a statewide locality.

MS. BURKE: I'm sorry. That's my fault.

DR. MILLER: I'm glad we could respond to that request.

Bob, to your point, we certainly could devise a thing like that. But I think if I understand what you're

saying, that means two counties could be right next door to each other and paid very different rates. At least one of the things that people get excited about is that very phenomenon. So you would be saying --

DR. REISCHAUER: But they'd only be paid very different rates if their costs were very different.

DR. STOWERS: [Inaudible].

DR. REISCHAUER: That's a whole different issue that you brought up, that maybe we have flawed methodology to begin with.

DR. MILLER: Are we done? Say yes.

MR. HACKBARTH: I think we're past done, actually. Thank you, Dan.

Next up is a discussion of practice expense or one specific facet of practice expense.

MS. RAY: Last month Ariel and I raised some issues about data sources CMS uses to calculate practice expense payments. This work fits into our broad agenda to examine physician payment issues, including the SGR and the unit of payment.

Recall that in our March 2006 report we made a series of recommendations to improve CMS's process for

reviewing work RVUs. These recommendations address the concern about the mispricing of services in the physician fee schedule. The Commission and others have argued that inaccurate pricing may be leading to increased volume in areas such as imaging. We are now turning our attention to the other major component of the fee schedule, practice expense. Our analysis of practice expense also addresses this pricing issue. In today's session we are focusing on the practice expense RVUs for imaging services, MRIs and CT scans.

This is behind tab K of your mailing materials. This is a draft chapter for the June 2006 report.

MR. HACKBARTH: Thank you, Nancy.

MS. RAY: You're welcome.

Practice expense payments are important. They account for about half of the payments to physicians. Given the magnitude of the dollars involved in payments can boost volume for certain services inappropriately and undermine access to beneficiaries' access to care. Some of you have expressed concern that inaccurate payments can make some specialties more financially attractive than others. These are all points that were raised in our study on work RVUs.

CMS divides practice expenses into two categories, direct and indirect. For most specialties, indirect costs account for about 60 percent of total practice costs.

Recall last month I told you that CMS uses a micro-costing database of the direct practice costs incurred by physicians to provide nearly all of the 7,000 or so services paid for under the fee schedule. We are concerned that CMS overestimates the practice costs for certain imaging services -- MRIs and CTs -- because the equipment use rate may be too low and the interest rate -- that is the cost of capital -- may be too high.

So let's first address the equipment use rate. To derive the cost of a unit of equipment per service CMS multiplies the number of minutes it's used for that service by the cost per minute. The cost per minute is based on the equipment purchase price, how frequently it's used, the cost of capital, and other factors. The frequency of use assumption is very important. If equipment is used at full capacity, the cost is spread across many services and the cost per service is lower.

By full capacity we mean that the piece of equipment is used during all hours the practice is open for

business. If equipment is used at lower capacity, the cost is spread across fewer services and the cost per service is higher.

Right now CMS assumes medical equipment is used 50 percent of the time.

Imaging services are diffusing. CTs and MRI machines are expensive and providers may have an incentive to use these machines, to the extent possible, to cover their fixed costs. This raises the question of whether CMS's 50 percent assumption is appropriate for MRIs and CTs.

It's important to note, I want to raise a technical issue, that the technical components of most imaging services are not currently valued using the direct inputs including the 50 percent assumption. Instead, right now CMS bases them on historical charges. However, CMS has given a strong indication that it will eliminate the charge-based approach and will instead use the direct inputs to value imaging services. Thus, it will be very important to make sure that the inputs, especially the equipment costs, are accurate.

We wanted to see whether it would be feasible to collect data on how frequently imaging machines are used

through a provider survey. We focused on MRI and CT machines because of the rapid growth of these services and the high cost of these machines. We surveyed providers in six markets listed on this slide who billed Medicare in 2003 for MRI or CT scans. Ariel took the lead on this survey.

We chose these markets because they represent a range of geographic areas and a range of per capita Medicare spending.

Our survey had a high response rate, 72 percent. Based on the information we collected, we calculated the use rate for each provider. We then calculated both medians and means across markets.

We found that across all markets the median use rate for MRIs is 100 percent. That means that 50 percent of the respondents are at or below 100 percent and 50 percent of the respondents are at or above 100 percent. The median might be thought of as representing the typical provider.

At the other upper end of the distribution a small number of respondents had use rates above 100 percent. That is they used their equipment for more hours than the facility was open for business. Some of these providers said that they see patients with urgent needs outside normal

business hours or that they perform studies on urgent patients during normal business hours which causes delays for scheduled patients and forces the center to operate longer than usual.

The mean use rate across all markets for MRIs was 91 percent and the 95 percent confidence interval on that value was 85 percent and 97 percent above CMS's 50 percent use rate assumption.

Let's move to CT use now. The median use rate for CTs is 75 percent. The mean use rate across all markets was very close to that, 73 percent. And the 95 percent confidence interval ranged from 65 percent to 81 percent, again above the 50 percent assumption rate.

This survey is a first step in examining the use of imaging equipment. It was not nationally representative and it was not designed to determine equipment use rates. Its intent was to assess the feasibility of getting use rate data from the survey. It shows that a the short survey instrument can be used to collect information on how frequently equipment is operated while achieving a high response rate.

It also raises questions about CMS's assumption

that MRIs and CTs are used 50 percent of the time.

Now let's look at another factor CMS uses to calculate the cost of medical equipment, the cost of capital. This refers to the interest rate on a loan or the opportunity cost of money spent to purchase equipment. In CMS's formula, they assume that providers pay an interest rate of 11 percent per year when borrowing money to buy medical equipment. The current assumption, developed in 1997, is based on prevailing loan rates for small businesses which are used as a proxy for physician practices.

We were not able to locate a current source of data on small business loan rates. However the Federal Reserve Board collects quarterly information on commercial loans made to different types of providers. The information from the Federal Reserve suggests that CMS's assumption is too high.

Based on the Federal Reserve survey data for the first quarter of 2006 the highest risk loans of more than one year had an average annual interest rate of 8.5 percent. The lower risk loans were 7.7 percent.

So to sum up our presentation, we provided evidence from the survey that providers in at least some

markets, six markets, are using their MRI and CT machines more than 50 percent of the time. We found a more recent source of data on interest rates which suggests that CMS's current 11 percent interest rate assumption for loans to purchase equipment is too high. This evidence raises questions about CMS's assumptions in how they're calculating the medical equipment practice expense costs in their micro-costing database.

Consistent with CMS's statements of making payment for imaging services resource-based, changing the use rate and the interest rate would lower practice expense RVUs for MRI and CTs and these RVUs would be redistributed to other services, budget neutral.

We are interested in getting your feedback on today's issues, as well as the draft chapter.

Finally, Ariel and I will be continuing to work on practice expense issues throughout the summer, including the one that you raised, Ray, about the GPCI adjustment for national versus local.

MR. HACKBARTH: So this becomes an issue only for when CMS moves to a bottom-up calculation of practice expense; is that right?

MS. RAY: No. Well, partly yes.

This becomes an issue once CMS pulls these nonphysician work services out of -- when CMS eliminates the nonphysician work pool and treats these services as they treat all other services. So this will happen even if CMS keeps the top-down method.

MR. HACKBARTH: Okay.

On the issue of the utilization of equipment, you gave us a little survey data that suggests that the 50 percent number at least it is not an accurate representation of this sample.

To me a question is whether this ought to be an empirical estimate of actually use or whether this ought to be a normative statement about what constitutes an efficient provider. I guess I would be inclined to the latter, as opposed to the former. I welcome reactions from Nancy and others on that.

DR. MILSTEIN: I agree with that principle and I think, in addition, I would comment that per this discussion and our prior discussion one of the things that the last two sessions have surfaced is the lack of regularity of updating things that bear directly on payment fairness.

In the last discussion we're looking at payment boundaries that were determined in 1966, unless there was a misprint on the slide. And here we're looking at an interest rate that was set in 1997.

If we're really interested in payment fairness we need some kind of -- cutting across all of our udpates -- a rule that says we never let information be more outdated than X years before we update it.

DR. SCANLON: I'm certainly not against efficiency but I think that we have to recognize that the circumstances will vary. The fundamental goal of Medicare payment policy is making sure that you have access for Medicare beneficiaries at an efficient price. Depending upon the community, how densely populated it is, et cetera, maybe we should think about are we willing to pay for equipment to be used less frequently so that people don't have to go 50 miles or 100 miles to get that kind of a service.

So we've used the actual experience and so far we haven't gotten into trouble with it.

We do need to think about how to become more aggressive about encouraging efficiency, but at the same time I don't know if we can use an arbitrary -- it's not

arbitrary -- a norm for efficiency because it's going to turn out to be conditional upon many things.

MR. BERTKO: To partly counter Bill's comment, particularly in area of imaging though, your normative -- particularly where we know it's 100 percent, and if a community has 10 imaging machines and the 11th one going to be used 10 percent of the time, I'd still stay with the norm because that's maybe what's called for today.

DR. REISCHAUER: Nancy, did you break down these usage rates by physician offices versus imaging centers? You said the sample contains both. I didn't know if there was a big difference between those.

MS. RAY: We do have that information.

DR. REISCHAUER: Is it large? Significantly different? It couldn't really be because I think over half of them were physician's offices.

MS. RAY: I do want to caution that this survey is not representative anything.

DR. REISCHAUER: But it does suggest that 50 percent is wrong, is way too low.

MS. RAY: What I can tell you is, for example, the IDTFs were open for more hours than the physician groups and

that the average hours that the MRIs and the CTs were used was lower in physician offices versus IDTFs. Does that help?

DR. REISCHAUER: It doesn't answer the question.

MS. RAY: But I don't have the equipment use rates by --

DR. REISCHAUER: You've given me the numerator but not the denominator.

MR. HACKBARTH: Bill, the point you raise is a reasonable one but it actually applies if we try to use an empirical estimate as well. The actual use rates may vary based on community conditions and the like. So if we use a single rate, whether it's empirical or a normative standard, we might have problems in unique circumstances.

So let me just focus on the normative idea for a second. If we were to go down that track in this particular area, would that implicate other areas of payment policy? Would we be breaking new ground that have ripple effects for other types of providers? And we'd need to think that through before we rush down this path? Any reaction, Mark or Nancy or anybody? Can you think of other places where this would have a ripple effect?

DR. MILLER: I'm more sympathetic to the second half of your comment in the sense of without being able to draw up specific examples I think we should think about this, because I do think it begins to ask questions about what is the underlying philosophy of these payment systems? Are getting prices accurate versus accurate for the efficient provider.

And I think to pick it in an area like this, it seems so clear and so it's easy to want to just go that way and say come on, this must be what we want to do. But I think I would caution that we think a little bit about it rather than state it as this is the principle and we're good to go, that we think about -- we think about holding off on that.

And here more the driver is that the data is suggestive that this assumption is wrong, raise that as a concept. But I wouldn't rush to it right off, for myself anyway.

DR. MILSTEIN: I certainly agree with the concept of looking a few moves down the chessboard before proceeding. But that said, I think we've gotten a pretty strong signal in the MMA that beginning to recalibrate our

recommendations to what's needed for efficient provision of health care is the direction that Congress wants to go. So obviously we need to -- this has implications throughout every -- that, in turn, has implications for almost every decision we make.

In many cases, as Glenn has pointed out previously, we're not in a position to implement that general concept. But where we come across opportunities to implement it, it seems to me we ought to tilt toward pursuing it.

DR. MILLER: Again, this is not to disagree. This is just to sort of think down the chessboard. I do embrace that principle and I think it's absolutely important. I think it's a question of where in your system you want it to happen. Just sort of harken back to the discussion about the quality. Do you want to build the metric on occupational mix based on the quality provider? Or do you want to build the metric to be relatively -- all right I'm just trying to get an accurate adjuster here, and then reward efficiency quality as sort of a separate transaction?

That's really what I'm trying to get it. Do you build it into each of your indexes as you're going through

your systems? Or do you really think about trying to incent that almost above this?

And that's not a yes or no. That's the three steps down the chessboard I would try and think.

DR. SCANLON: I would agree. In some respects, we aren't really operating even on the empirical level purely. We're operating on it to a degree and then there's a lot of slack that we've built into the rates and so far we've gotten along okay with that.

With Arnie's point, we do need to move towards better rates in terms of trying to be making the Medicare program an efficient provider, and efficient purchaser. That's somewhat different than saying we're going to look at what the efficient provider is doing because there are other circumstances that we have to take into account.

The prior discussion about physician areas, we brought up this idea of we've got the costs in areas but then we may have issues of trying to attract physicians to these areas. We may have two separate mechanisms, we may have the GPCIs and we may have the rural add-on.

But when we start to think about adjusting one, are we able to adjust the other one simultaneously in the

right way?

We've got so much built into our payments right now that are not quite perfect, to make want one part perfect may have consequences that we find very undesirable. And so it is thinking several steps down that chessboard, knowing what we can change to influence the bottom line so that we preserve the access that we want, that we then promote quality and we promote efficiency.

That's the only caution. It's not one that we can't improve but it's a difficult job of doing it.

As I remember when practice expense was first introduced and HCFA at the time had the bottom-up method, the assumption of 50 percent was challenged as being too high. Whether the challenge was valid is another issue but there were certainly people approaching the Congress saying we're being penalized here because we can't use our equipment that frequently.

Even in this, knowing the percentage is, in my mind, not enough. If you really want to do this appropriately, you need to think about what's the cost per use. So if people are operating different numbers of hours, we want to know how many units do they get out of this in a

day. That's what the cost is that we should actually be calculating.

There are many, many steps down the road that we need to think about before making big recommendations here.

DR. KANE: Might this be the same kind of problem as new services versus existing? That originally it was set fairly low because it would just be disseminating and now it's pretty established? I mean, how rare -- how hard is it in rural areas these days to find an imaging center? I've heard that that's the only thing people can afford now. It's so remunerative that everybody's got one and they're on every corner in rural areas, as well as -- that's probably a gross exaggeration.

Is this the same kind of problem as new services in the physician fee schedule versus ones that have been out for a while? And should we apply a similar kind of rule that after a while we should do revisit any capacity assumption and assume it's pretty well disseminated and then adjust it for the efficient provider at that point?

I can see where 10 years ago maybe 25 percent was asking for a lot. I just wonder now if it's all that hard to get an MRI or a CT scan anywhere.

DR. WOLTER: I think it's certainly true that many rural, even critical access hospitals, are now putting advanced imaging in because you really can get about a bottom line out of a relatively few studies per day, which I think would certainly support the fact that maybe 50 percent isn't the right number.

Sometimes I feel like were too cautious and I know we need data and we need to be able to justify what we're doing. But you look at the explosion of volumes in certain areas, whether it's specialty hospital or imaging or whatever, and we have a crisis that we're headed into just over the next few years. There are many reasons to fall on either sides of the argument.

The main reason I would put out that we have to be cautious with imaging is that it's one of the five or six profitable areas that both physicians and hospitals can look at. And if we're going to provide mental health and geriatrics and care for medical illness, all of which you lose money on, making changes in this without addressing those creates problems for providers.

But as a stand-alone issue, is there huge profitability in imaging? Is that driving behavior? Can

people make a lot of money with a fairly low volume per day? The answer to all of those questions is certainly.

MS. RAY: I just want to clarify a point. The 50 percent assumption that CMS uses in its CPEP or direct input database, it uses that assumption for all medical equipment not just MRIs and CTs. We have focused on MRIs and CTs because that's where this assumption makes a big difference because these machines are so expensive, $1 million to $2 million, versus a $500 new table for example. The assumption doesn't have the same impact. But this assumption is used across all of the nearly 8,000 services that's in this micro-costing database, this 50 percent assumption.

DR. KANE: Do you know where it came from?

MS. RAY: I was looking to Bill for a little help.

DR. SCANLON: It appeared and was challenged. That's all I remember. But I think a key thing though is that in the top-down method what we're talking about is allocating the amount that's spent on equipment. So it's very different than if we're trying the true bottom-up, which is to make a set of assumptions and get a set of data and combine them and say this is what the relative value is.

Because to the extent that only certain specialists have CTs and MRIs, and we've got their pool of actual spending, we've got to control or we mitigate the role of the assumption. But again the true bottom-up method is going to eliminate that control.

DR. NELSON: The chapter makes the point that if we recalibrated the expenses as suggested, the savings would be redistributed. And to meet the concern that Nick expressed, I think we need to be pretty strong and make sure that those savings were redistributed, should be redistributed in a way that provides better support for those things that aren't currently paying for themselves.

MR. HACKBARTH: Okay. Thank you, Nancy.

Last for today we have our annual response to the CMS initial letter on the physician update.

DR. NELSON: Are we doing Part A tomorrow?

DR. MILLER: Tomorrow is the physician resource use, then the inpatient resource use and outpatient therapy. This is the physician update latter.

MR. HACKBARTH: He was asking about the inpatient resource use. That is the second --

DR. NELSON: The CMS proposed rule for acute

inpatient --

DR. MILLER: I'm sorry that that's confusing things. You should be looking at this thing that says review of CMS's -- with Kevin Hayes' name on it. That inpatient thing, that was just a summary of the rule.

DR. NELSON: So this is not a presentation. This is just a summary for our information.

DR. MILLER: Right, for your information.

DR. HAYES: As Glenn said, we're going through our annual process of reviewing this early estimate from CMS on the payment update for next year. Were required to include a review of this estimate in the June report.

From a staff standpoint, a conclusion for the review is that in calculating the update, CMS has used the best information available consistent with recent trends. Even if their estimates change between now and the fall it's unlikely that the update will be anything other than a maximum reduction permitted under law because of trends in spending for physician services that have played out over the last few years.

CMS's estimate is shown here. The bottom line is the number, an update of minus 4.6 percent. It's composed

of two things, change in input prices of 2.6 percent and an update adjustment factor of minus 7 percent.

The update adjustment factor, if not for a limit in law, would be much bigger. It would be a minus 28 percent. And for that reason we feel like there's really no likelihood that the update would be anything other than the maximum negative update permitted under law. The numbers would just have to change too much in order to alter that update adjustment factor.

The reason for this negative update is the large gap that exists between actual spending for physician services and the target that's determined by a sustainable growth rate. Just to illustrate, in comparing 2004 to 2005 the sustainable growth rate was 4.6 percent. Actual spending grew by 8.5 percent.

The reason for this disparity has to do with growth in the volume of physician services primarily. There is an allowance in the SGR for volume growth and that's growth in real GDP per capita, whereas actual volume has been much higher than that. If we look over the period since the inception of the SGR, the volume growth, actual volume growth, has been growing at an average annual rate of

5.3 percent. Real GDP per capita has been going up by 2.1 percent on average per year.

Where is the growth occurring? As you know, the Commission has been looking at volume growth by type of service. And the information that we have from CMS is roughly consistent with what the Commission has been finding.

We don't have volume numbers by type of service in the information provided by CMS, but at least in terms of spending, particularly if we could look at these first three categories of services: evaluation and management -- which is mostly visits -- procedures and imaging, we see that the most rapid growth is in imaging.

I would make just one point about the drop in spending for Part B drugs that's shown here. That's composed of two things. One is an increase of volume of 23 percent but a decrease in prices of 21 percent. We're looking here now at what happened in 2005 and that was a year when there was a transition from paying for Part B drugs at 85 percent of AWP and going to average sales price plus 6 percent.

Just to put all of this in some kind of

perspective, we can think now about what the Commission is doing in the area of physician payment and what we see. First, listed here is just this issue of mispricing as an area of emphasis for the Commission. What we've focused on here most recently is changes in the way CMS conducts the five-year review of physician work. Recall that you made some recommendations on that in the March '06 report.

We've just heard about couple of other physician topics, practice expensive and geographic adjustment of payment rates, all focusing on this question of whether Medicare is paying accurately for physician services.

In addition, you'll be talking tomorrow morning about measuring physician resource use and accounting for the efficiency with which physician services are furnished.

And lastly we are, as you know, working on a report for the Congress on alternatives to this SGR policy. The report is due in March of 2007. You will recall you heard a presentation on a work plan for that in January and in upcoming meetings we will be presenting parts of that report as they are ready.

That's it.

MR. HACKBARTH: Questions or comments for Kevin?

DR. MILSTEIN: Question. In our last meeting we discussed overall Medicare spending as a potential frame of reference. Can anybody remind me what the percentage point gap is more recently in annual growth between Medicare per capita spending and GDP growth?

Obviously, slide three shows a certain percentage gap, which I'm going to infer is larger than the gap that I'm referring to. It's a potential frame of reference on whether or not -- I understand.

MR. HACKBARTH: You're asking for total Medicare as opposed to just Part B?

DR. MILSTEIN: Right, if physician activity influences total Medicare spending growth in addition to spending growth across this narrow market basket of services.

What I'm asking for is -- if it's not available now at some point along the way -- some frame of reference on how physicians as a group are doing in rate of growth relative to GDP on total Medicare spending rather than just the subset of services that are currently in the basket.

MR. HACKBARTH: So the total figure in recent years has been just about GDP plus 2 percent or slightly

under that, 1.8 percent.

MR. BERTKO: I believe that the National Health Expenditure stuff has accounts that would do that and that's the stuff that gets poured into the Trustees report which, as we've heard, may be coming out sometime.

MR. HACKBARTH: Rachel presented on that if not at the last meeting, two meetings ago, and it was about 2 percent, GDP plus 2 percent.

DR. MILSTEIN: 2.5 points for all spending, for Medicare spending.

MR. HACKBARTH: For overall Medicare spending relative to GDP.

DR. MILSTEIN: And what annual rate of growth is implied in slide number three? What's that gap? Is that more or less than two points?

MR. BERTKO: It's about the same. It's five versus two.

DR. MILSTEIN: Five versus two.

MR. HACKBARTH: The growth rate for Part B has been faster than Medicare overhaul so the gap would be larger for -- do you know what's the number, Kevin, underlying the graph?

DR. HAYES: No, I don't know.

DR. MILSTEIN: As we cast about for alternatives, which I guess will be on our agenda in the fall, I think it's a frame of reference that would be useful because in many cases there is an increasing on average shift away from inpatient care. And in some ways the old SGR formula does not take that into account. In fact, it penalizes physicians in that way.

MR. HACKBARTH: Okay. Anything else on this?

We'll have a brief public comment period.

MR. FENIGER: If I may, I know you've missed me.

Randy Feniger with the American Surgical Hospital Association, and I'd like to just take a few minutes to comment on some of the observations during your discussion.

I certainly appreciate the quality of the second analysis that was done with a larger database and also appreciate the time the staff had spent with us earlier to discuss some of the issues that were dealt with in greater detail today.

Just quickly, the question of the relative costs of specialty hospitals versus other hospitals is kind of a conundrum. You have talked about that. We have talked

about it among ourselves. I think more answers came out in this analysis, but quite frankly we really don't know why that data shows what it does.

We'd like to see a little more focus on the length of stay since it is so significant. And perhaps that might be an area for further exploration. Perhaps there are some lessons that could be learned and applied to a broader array of facilities. Why do we have that length of stay? Is it the staffing? What else could be learned?

Medicaid came up, and I would like to comment on that. There was, I think, some excellent points made about that. But one I want to add to that, in many states Medicaid, as you know, has moved to a managed-care model. So there are selected contracting with hospitals in those states.

If you don't have a contract with the state system, you're not going to get Medicaid cases. It may make sense from the states point of view to contract primarily with full general community hospitals as opposed to specialty facilities. That's certainly the case that we've seen in California where they have just bypassed all of the specialty hospitals and gone to larger community hospitals.

So I think that's an additional reason to think about on the Medicaid distribution, in addition to the points that we're already made. I don't want over those because I think this is an issue that just keeps recycling. But there are many reasons, as was discussed, why Medicaid distribution is the way it is among all hospitals.

Size and occupancy, as you probably know, CMS Administrator McClellan has identified this as a specific issue, really the definition of a hospital. We expect that they are going to be coming out with a report, probably May or perhaps in the summer, I don't know if the time frame is terribly firm, that will address that specific question. It may shed some light on how the department intends to respond if they feel a response is necessary. But I wanted to add that that is very much underway and on their radar screen.

On the competitive response that was discussed, I would be interested in how hospitals compete with each other when there is no specialty hospital in the community. If we find the same kinds of responses, for example hospital A hires away the cardiovascular team of hospital B, what does hospital B do to make up that difference? They probably have the same set of options that they have to respond to a

specialty hospital. But I would be interested if that is an area of concern to the Commissioners that perhaps looking at some other areas in competitive response might be helpful in addressing that more completely.

And finally we would ask, as an industry, to allow the DRG changes that are now underway to be fully implemented and fully absorbed. I would like the record to reflect that we are not the organization who is trying to shut down competition and opposing those recommendations. In fact, we have supported the recommendations of MedPAC specifically on the DRG changes and refinements.

We would simply ask that you allow time for those to be fully implemented before coming back and addressing this issue again. Because I think, as was pointed out, it could have a significant impact on the behavior of physicians, investors, hospitals of all kinds, and we think that needs to play out before we go any further with that issue.

Thank you.

MS. McNEIL: Hello. My name is Elizabeth McNeil. I'm with the California Medical Association. As Dr. Crosson said, I have flown out from the left coast to be with you

here today.

I just wanted you first thank the Commission for looking at this Medicare geographic payment issue. We are very grateful to you for doing this. It has plagued the California Medical Association for about eight years now and we have taken numerous proposals to CMS and to Congress to try to get this problem fixed.

Many of those proposals were budget neutral. We're trying to proactively solve it ourselves. So we are very appreciative of your willingness to look at it and study it further.

I would like to just tell you that we believe that this is a national problem and it's a large problem. Physicians in 32 states are inaccurately paid. So this is not just a California problem. It's New York, Texas, Illinois, Missouri, Ohio, North Carolina. I can go on and on and name you those states, but it's a significant problem in 32 states.

It is also a problem if you are in one of these counties that is underpaid. It is a significant problem for those physicians. The payment inaccuracy rate in these counties is up to 14 percent.

Now there are only 30 counties in the country that have a 10 percent to 14 percent problem. But in those counties that's very significant and many, many other counties are underpaid by 5 to 10 percent.

I will just give you an example. In California our Santa Cruz County, which was mentioned earlier, they are underpaid -- they have a Medicare cost factor that is assigned to them. And they are paid 10 percent less than that cost factor. They are paid 25 percent less than the Palo Alto physicians across the border. And their cost factors are only differentiate between 2 or 3 percent. So it's a major difference in payment when their cost factors are very similar.

Santa Cruz County, I will just tell you, we think there are access problems appearing in these underpaid counties. Just for an example, in our Santa Cruz County, all of the physician groups there over the last couple of years have not taken new Medicare patients. The last group that has agreed to take them as of June 1 this year, none of the physician groups in Santa Cruz County will be taking new Medicare patients. So we're going to see some significant excess problems appear there this summer.

I just want to also mention that we believe these problems were created largely by the overhaul that HCFA did in 1997 by consolidating the localities and creating this larger payment error.

But I would like to leave the Commission with three thoughts about going forward. Because we have had extensive conversations with our members of Congress and are delegation -- so has Texas and New York -- and with CMS about this issue. I think Congress, CMS and certainly the physician community are really seeking guidance from MedPAC on, first of all, a validation of a methodology. I think there's a great deal of interest in Congress in solving this problem in CMS. They're interested in doing it on different levels. But, I think they need someone other than the CMA to say we like this 5 percent threshold idea. They would like some validation from MedPAC to say what they think an appropriate methodology would be.

We have steered away from the MSA approach, I will just tell you, because it has changed things for counties and physicians where there is not a problem. It's a major overhaul in the country and we have considered if it ain't broke there, don't fix it. But we're certainly open to that

idea.

If you did move to an MSA approach though, I think we would recommend that you look at just moving to a strict MSA, not using the 5 percent iterative approach. If you want to move everyone to MSAs, just move them to an MSA. I don't think you need use the 5 percent approach to do that.

But we have obviously preferred the 5 percent county-based threshold.

The second issue is an issue of budget neutrality. This becomes a very difficult problem because if you help these underpaid counties and move them out to new localities, you then inflict payment reductions on basically suburban mostly rural counties. And in California, the payment reduction would 4 to 6 percent in our rural counties. That's been very significant.

And we, as an association, have not been able or willing to want to inflict these kind of payment reductions in the rural areas.

So most recently we had talked to Congress about a budget supplement. The cost of fixing all the counties across the country is $300 million. The cost to only fix the multi-locality states is $115 million. So the cost is

very minor in the scheme of things. I think that's an issue that you, as a Commission, will have to wrestle with is whether you want to do this on a budget neutral basis or not. I understand you much prefer budget neutrality but it becomes a very difficult issue when you look at the rural counties.

And finally I just do want to mention that the process to this date has been a political process. And so I'm very encouraged by the discussion to look at setting up a process for updating the localities that is formula driven and that is automatically updated. CMS not by law, not by regulation, but by their policy have put the state medical associations in the middle and wanted our approval before any change could occur. Of course, that's been very difficult to do that.

And so we would much rather see a process that is formula driven than a political process in order to achieve payment accuracy in the system.

so thank you very much for your time today and for studying the issue.

MS. McILRATH: I'm Sharon McIlrath. I'll try to be brief since it's late.

I just wanted to second the comment that as you go forward and do your volume report that you try to look at the total pot of money and see whether some things that are happening on the physician side may be driving some reductions over on the hospital side. Certainly last year they did comment that the increases on the hospital side were lower than had been anticipated.

I also would encourage you to drill down. When you look at the total SGR pot, the utilization of the drugs is driving the number up. So if you were looking only at the fee schedule services you would see lower growth. And when you wiped out the things that were legislative and the legislative pay cuts then you would find that the growth on the physician services themselves is closer to -- and this would be the volume and intensity, not the spending -- would be closer to 4 or 5 percent. So take that into consideration when you're making decisions.

Also, remember that these are preliminary numbers and they do change. If you read that letter that CMS sent, last year at this time they said the increase in expenditures was 15.2 percent. In the end they decided it was 11.4 percent. And it was particularly off on certain

kinds of services.

For instance, they had said that the growth on the E&M services was about 15 percent. It actually turned out to be 8 percent. So when you're looking at which services are growing and what sorts of things you ought to be looking at, keep that in mind.

And I will just say that our numbers guy, and his track record is very good, and it was closer last year than the CMS estimate, is finding that the imaging, while it's still growing, has sort of trailed off a bit from where it was. That doesn't mean that anybody shouldn't be looking at imaging. It just means that you need to maybe go back and do a look back.

And then finally, to keep in mind that a big part of our problem is not just the volume. As much of the problem, at least up through 2005, was due to the unfunded congressional fixes. That is that basically they increased the payment rates for 2004 and 2005 but they didn't increase the target. So essentially it wasn't that they gave physicians money. They loaned physicians money and they're to get it back by longer, bigger cuts in the future.

So that was, through 2005, about 36 percent of the

problem, whereas something somewhat less than that was due to volume increasing by more than the target.

MR. HACKBARTH: Okay, thank you very much.

We'll convene tomorrow morning at 9:00 a.m.

[Whereupon, at 5:12 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Thursday, April 20, 2006.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, April 20, 2006
10:15 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. DeBUSK
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: We begin this morning with two presentations on measuring resource use, starting with physicians.

MR. BRENNAN: Thanks, Glenn.

Good morning. Today we'll be presenting our latest findings related to our assessment of two commercially available episode groupers and how they perform on Medicare claims and their suitability for measuring physician resource use.

To briefly review, the two of groupers we're using are episode treatment groups created by Symmetry Data Systems and the Medstat episode grouper created by Medstat. In addition to the resource use component of the analysis, we are also calculating a set of claims-based quality indicators for the same population.

At the March meeting and today we'll be presenting the results of our analysis using a 5 percent sample of Medicare claims. Once this report cycle concludes, we'll begin analysis of 100 percent of claims in selected geographic areas, permitting us to build on the lessons we have learned from the 5 percent analysis and begin to

construct physician-level caseloads, resource use scores and quality scores.

At the March meeting we presented some results which I've quickly recapped here. There were a high proportion of claims and dollars that grouped in both groupers. We found broad agreement between the two groupers. We examined the composition of episodes by type of service and we tested a variety of attribution methods for both the resource analysis and the quality analysis.

The next area we wanted to examine was variation in resource use by MSA. As you all know, previous research -- most notably that performed by researchers at Dartmouth -- has found that there is a large variation in per capita Medicare costs in different parts of the country.

One thing to note here is that to date, as these tools have been used in the private sector, they have rarely if ever been used to compare resource use across wide geographic regions. Because of the fragmented nature of health insurance coverage for the non-elderly, many different private insurance companies can cover the population of any given MSA. Therefore, in using these tools, most plans are merely trying to assess the relative

performance of physicians in their network in a given area, not to other non-network physicians in the same market area or broader regional comparisons.

So one of the things we will be examining is whether the groupers can control for regional differences in patterns of care or volume.

This table highlights relative resource use scores for several MSAs on some of our selected conditions. If you recall our presentation from last month on the types of services within each episode, you can think of these five episodes as falling into two groups: chronic conditions that tend to have low levels of acute care usage, hypertensive and diabetes, and those that have higher levels of inpatient usage, CHF and CAD.

If you look at the first row the table, we present the national average cost for each episode: $423 for high blood pressure, $833 for Type I diabetes, and so on. Remember that these dollars have all been standardized so they are comparable across regions. We've also shown the N there, the total number of episodes for each group.

The remaining rows detail for each MSA their average cost for these episodes relative to the national

average. These represent relative resource use scores for all beneficiaries with a given episode in each MSA. You can see that for high blood pressure Minneapolis has a relative resource use score of 0.87 compared to 1.2 for Houston and Miami. This means that per episode costs for high blood pressure episodes in Minneapolis are 13 percent less than the national average, whereas they are 20 percent higher in Miami and Houston. Minneapolis also has lower relative resource use scores compared to other MSAs for Types I and II diabetes.

However, the pattern of relative resource use changes significantly for coronary artery disease, CAD. If you look at the less column of the table, both Miami and New York City have relative resource use scores of considerably less than 1.0 while Minneapolis has a relative resource use score of 1.28.

We were a little surprised at this finding so we decided to delve a little deeper into the data.

[Laughter.]

MR. BRENNAN: What we found was that it may help to look at more than just per episode costs in order to get the fullest picture of resource use. This table presents a

number of statistics that may or may not be helpful in parsing exactly what to make of the large gap in relative resource use scores for CAD between Miami, which has been identified in the past as a high resource area, and Minneapolis, which has been identified in the past as a low resource use area.

One of the first things we found was that Medicare beneficiaries in Miami were more likely to have a CAD episode than beneficiaries in Minneapolis: 11 percent of Medicare eligibles in Miami had a CAD episode compared to 6 percent in Minneapolis.

We also looked at the total number of episodes for beneficiaries with a CAD episode in each MSA and again found that beneficiaries in Miami when CAD tended to have more total episodes than beneficiaries in Minneapolis. Further, beneficiaries in Miami had more other heart-related episodes than beneficiaries in Minneapolis

However, when we looked at the total dollars associated with these episodes, the total episodes, the relative resource use scores were quite similar between the two MSAs. So while CAD patients in Miami have more episodes, they have similar levels of resource use to CAD

patients in Minneapolis.

Now I'm going to move from focusing on CAD to focusing on all patients, all episodes. And again, comparing these two MSAs on a per episode basis, Miami is again lower in terms of relative resource use than Minneapolis. Across all episodes Miami has a relative resource use score of 0.98, whereas Minneapolis has a relative resource use score of 1.03.

However, when we move to a per capita notion you can see that the result changes quite dramatically. On a per capita level Miami's relative resource use score is 1.32, whereas Minneapolis' is 0.88.

MR. SMITH: The total dollars per beneficiaries, is that all Medicare dollars or all Medicare dollars related to episodes?

MR. BRENNAN: Are you talking about the fourth row on the table?

MR. SMITH: Yes.

MR. BRENNAN: That's total Medicare dollars for all beneficiaries with a CAD episode.

MR. SMITH: So it's all dollars for anybody with an episode?

MR. BRENNAN: With a CAD episode, yes.

MS. BURKE: In the course of reading the chapter, I thought one of the comments made was that there were certain things that we couldn't easily track to a particular episode, certain expenditures. Is that not the case? Or was that just with respect to docs? Pharmaceuticals, as I recall, and there was one other. Is that related to docs?

MR. BRENNAN: We don't have any data on drug claims because there's no drug benefit. But everything else should be in there and is relatively easy to track. You know, you would just identify the beneficiary and then identify all the other care that they have. Perhaps there's something in the chapter that we miswrote.

MS. BURKE: I thought there were two. Drugs was one and I thought there was a second that you couldn't capture by episode. But go ahead, everything but drugs.

MR. BRENNAN: We also didn't look at DME claims, for example. But we covered the majority of things, hospital inpatient, physician, hospital outpatient, home health, SNF, et cetera.

So these results raise many interesting issues in using episode groupers to measure resource use. At a first

glance, if you just focus on the per episode relative resource use scores you might conclude that Miami is more efficient than Minneapolis in the treatment of CAD.

However, what seems to be happening is that beneficiaries in Miami are much more likely to have a CAD episode in the first place. So one thing that may be happening is that there are more low-cost CAD episodes in Miami, which combine to drive Miami's average for CAD down.

Additionally, beneficiaries in Miami are more likely to have more total episodes in addition to CAD episodes, particularly other heart-related episodes. Meaning that perhaps the prevailing coding patterns or supply of physicians in Miami are such that beneficiaries who in Minneapolis would remain in a CAD episode and continue to drive up costs in that episode are being classified into other episodes in Miami.

So perhaps a solution would be to combine a per episode approach to resource use with a per capita approach in order to control for differences in volume across regions. It's also possible that the grouper software packages could be further refined to adjust for episodes that are low in severity and have very low levels of

resource use.

We'll continue to explore this issue in our 100 percent analysis.

Another important factor that we have to deal with in using episodes of care to assess physician resource use is risk adjustment. From our experience in talking with people who have used these tools in the private sector a common reaction from physicians is that their per episode costs are higher because their patients are sicker. In order for these grouping tools to have face validity with practitioners, you have to be able to show that the groupers do not unfairly reward or penalize physicians based on the underlying health status of their patients.

Both groupers employ risk adjustment techniques. ETGs uses an approach known as episode risk groups or ERGs while the MEG grouper uses the diagnostic cost grouper method, DCG. Using these methods you can calculate a risk score for each episode and eventually build an overall risk score for a physician's panel of patients. In the next few sides we'll provide some examples of the MEG DCG risk adjustment approach.

This table is based on our current analysis and

illustrates how the use of risk adjustment can further refine how you look at a given episode. As you know from our presentation in March, the MEG grouper employs a disease staging approach which classifies most episodes into three severity stages based on the clinical severity of that episode. What the DCG adjustment does is create five overall patient severity categories for each stage of each episode, meaning that you can now look at 15 cells within a given episode.

This table headlights the risk adjustment of CAD episodes from our analysis and presents the average cost per each complexity level and each stage of CAD. If you look at the bolded and underlined and yellow cells in the table you can see that the average costs for a CAD episode range from a low of $564 for a stage 1 patient complexity level 1 episode to over $11,000 for a stage 3 complexity level 5 episode. Obviously you don't want to compare a physician who predominately treats the former with the latter.

You'll also notice that at higher complexity levels the values in certain cells can be the same. That's because some cells have their values merged in order to maintain an appropriate sample size.

This next table provides an illustrative example of how risk adjusted episodes can be used to adjust physician scores. For this hypothetical episode the average costs are a little over $2,000. That's the predicted cost in the bottom left-hand corner of the table.

Looking at the last two rows on the table you can see that physician number six has actual costs of $2,032 while physician number seven has actual costs of $2,405, resulting in relative resource use scores of 1.01 and 1.20 respectively.

However, when you incorporate information on risk adjustment you can see that the average risk score for physician number seven's patients is almost doubled that of physician number six's. When we incorporate this information into each physicians' predicted cost the relative resource use score for physician number six increases from 1.01 to 1.15, while the score for physician number seven decreases from 1.2 to 1.06.

With that, I'll turn it over to Karen for a discussion of our quality findings.

MS. MILGATE: We also looked at quality across MSAs using a set of claims-based indicators. We have over

30 indicators in the set so we grouped the indicators by condition to look at the MSAs. There's two types of indicators in this set. One type is the necessary care indicators, and just to refresh your memory on what that means it's using, for example, for diabetics whether over the course of a year they got the appropriate tests that they needed.

We also have some potentially avoidable hospitalization indicators in there. Again, using the example of diabetics, there the measure looks at whether someone who had been identified as a diabetic had been hospitalized for either short or long-term complications due to diabetes.

In the table below here we're only using the necessary care indicators and I'll describe why that is in a moment.

We found when we ran the indicators on the 5 percent sample that in general there was quite a bit of room for improvement on the indicators. You can look at the first row there in the table, that's the national average across all these indicators. So we have a composite diabetes score, a composite CHF score, and you can see the

numbers leave room for improvement on all of them really except COPD, which is fairly high, that there's 20 to 40 percent of beneficiaries -- at least in our 5 percent simple -- not getting appropriate care.

So then what we did is take that national average and compare it to MSA composite scores on the conditions. And so the rest of the table shows some examples of the MSA scores relative to the national average.

So for example if you look at the row for Chicago on the first condition, diabetes, you see that Chicago had a score somewhat lower than 71 percent. So their ratio is 0.95. But then for the next four indicators they were pretty close to the national average, slightly above in a couple of them. But still again, this is a ratio to a fairly low number.

Our analysis also provided information on several technical issues. Before we grouped the indicators by condition we considered whether each MSA scores were based on sufficient sample size and we ended up removing some indicators from the analysis based on low incidents and others based on low eligibility. Let me explain what I mean by that.

We removed all the potentially avoidable hospitalizations because at the MSA leveled by condition they occurred so infrequently. However, we are experimenting with creating an overall composite across condition of the potentially avoidable hospitalizations and may decide to add that back in when we look at the 100 percent analysis, depending upon what we see as the incidence level at the individual physician level.

Further, we removed any indicators with fewer than 30 beneficiaries who were eligible to counted. That would be the denominator for each MSA by indicator. We have heard from our expert panel, as well as others we've spoken with, that in fact that's a fairly conservative estimate, a fairly conservative threshold that's often used for these types of analyses.

So that meant that some of our indicators are not included by condition at the MSA level.

Because we began with over 30 indicators we needed to create composites and we created them by condition, as you saw in the previous table. We applied two different weighting methods to try to do that. When I talk about weighting methods, what I'm describing basically is how we

added up the indicators to create a composite score for the condition.

The first way we did it we called a straight average. There we just added up the specific indicator scores and then divided the scores by the number of indicators we had. So if we have a score of 71, 65, 50, we would add those up and then divide those by three, or however many indicators in the condition.

But this method weights equally indicators that apply to a lot of beneficiaries with the indicators that apply to a few beneficiaries. So what we did was also apply what's being called an opportunity model.

This method basically the concept is you're trying to look at all the opportunities a physician had to actually provide necessary care. And there, for each condition you sum the denominators or all the beneficiaries that are eligible. You sum the numerators, all of those that got the right care, and then divide the sum of the numerator by the sum of the denominator.

That does control for the number of beneficiaries that are actually eligible for something to happen to them that's considered high-quality care.

We did find that on the indicators that had very different denominators that certainly did move the scores around. So it would be important to consider that when we look at the weighting methods when we look at physicians individually.

One important caveat is that claims-based process indicators may move in the same direction as resource use. Both count whether services were provided. We found in our analysis because the scores group so closely and are relatively high in our MSAs it was hard to know how this may have affected our scores.

What we did then is add in then another outcome measure to see if, in fact, the relative rankings would change if we added in another indicator. So we used the combination of potentially avoidable hospitalizations across conditions, which actually would move in the inverse direction that the process measures would move. For example, if you had high process measures you'd also have high quality. Well, if you had high resource use on process indicators, you'd also have high quality. If you had high potentially avoidable hospitalizations you, in fact, would have low quality. So it moves in the opposite direction and

we wanted to see if, in fact, that would change the rankings.

And it did, for quite a few MSAs but not all of them. For example, Miami, if you just looked at necessary care, ranked 1.02. So around the national average, slightly above. Whereas if you looked at potentially avoidable hospitalizations they had 0.81, meaning that they looked lower on quality rather than higher. So it does change the rankings of the MSAs.

So in conclusion, just to sum up kind of all of what Niall and I have said here, we find that per episode resource use in the aggregate, particularly at the MSA aggregate, should be used alongside information on per capita spending as well as per capita number of episodes.

We will continue to look at this variation in the 100 percent analysis to see if, in fact, we see the same type of variation patterns within MSAs that we saw across MSAs.

We also find that a broader set of quality indicators, such as those the Commission recommended for pay for performance, may be necessary to ensure that quality is measured somewhat independently from utilization.

We'll continue to assess the use of these indicators but additional information on lab values, prescriptions and some of the discussion we had on care management processes would also be beneficial if the Medicare program intends on measuring efficiency using claims.

With that we open it up for your discussion.

MR. BERTKO: A number of comments. First of all, Niall and Karen have done an amazing amount of work here so, as somebody who's plugged through the data, let me just congratulate them on getting this much done for us.

Secondly, I think where they're headed next with the 100 percent file on looking within MSAs as well as across MSAs is pretty important. The across MSAs, to me, there are some surprises there. And they tell us that -- and not being a clinician, I'll just use the term generically -- best practices, that there may be a number of best practices that would affect the Medicare plan as a whole. Then within MSAs, to be actionable, you may need to roll it up on individual docs or within individual specialties to see where the issues are.

In fact, I guess I'd looked to Arnie for

confirmation but many of us who are doing this on the plan side are rolling up within specialties. So we take a number of episodes that a cardiologist would do, roll them all up together, balance them somehow, and then see what's going on there.

Because ultimately I think if we're going to help people identify what they should be doing, if this comes from here some normative data, then you need to be able to do -- for lack of a better term -- report cards or at least some reporting back on all of this.

The last comment here is the quality measures that Karen just talked about. This is, I think, a really important finding. We had done our quality efficiency comparisons mainly off the claims data, saw strong correlations, and in fact the insight that you have of looking at non-activity based type of quality measures, I think, is really important in order to get the best possible idea of how quality and efficiency are correlated.

DR. NELSON: I found this as interesting as John did.

I wondered, since a third of the claims that you subject to analysis had to be excluded because you couldn't

identify start and stop date makes you concerned about whether this technique is ready to be used, particularly in performance evaluation of individuals or small groups. Do I make myself clear?

If you can't tell when an episode started and stopped on one-third of the claims how confident are you that this is a useful tool? And then I have another question.

MR. BRENNAN: In terms of the clean starts and clean finishes, by eliminating an episode that you can't identify as having a clean start or a clean finish, in a way you hopefully make it fairer in comparison because you're not comparing a potentially very low resource use episode with one that has a full year of claims or whatever.

So I think, and this is just my personal opinion, sort of methodologically you could look at it as strengthening the analysis because it's fairer. You are losing sample size but in a lot of these things losing sample size is just a fact of life.

MS. MILGATE: I would presume what you're getting it is you might not be looking at really the whole of what a physician was doing because you're missing some part of it.

Is that where you're going?

DR. NELSON: Or whether there were particular conditions that were excluded that would skew your analysis when it came to any particular physician or group of physicians. I'm satisfied with the response, that that doesn't particularly shake your confidence in the applicability of this tool for performance measurement.

MR. HACKBARTH: Where they randomly distributed, the ones that are excluded because there's not a clean start or a clean finish?

MS. MILGATE: They should be.

MR. BRENNAN: They should be. We can check that.

MS. MILGATE: The other thing to note, Alan, it doesn't get at whether there's particular conditions that may be left out. But when we get to the 100 percent, we're going to have to make -- and everybody who uses these tools make some assumptions about how many episodes that you need to say that you've actually fairly measured a physician.

So what Niall is saying is we're only going to use those that we really know are episodes and then we'll have another threshold where we say and do they have enough to really feel that we've gotten a good picture of the

physician?

MR. BRENNAN: And by using clean episodes, you hope that you'll have the fullest picture of care for a given condition. And then every physician is going to have clean episodes that were kept and unclean episodes -- for want of a better word -- dirty episodes that were...

DR. NELSON: That satisfies me.

My second question has to do with potentially avoidable hospitalizations. As I understand your presentation, you were using that in comparing one MSA with another. That is, you were examining geographic variations around this particular factor, which would be -- which would be okay in my view. If you were using potentially avoidable hospitalizations in performance evaluations of individual physicians, that would worry me because over the course of 20 years of diabetic treatment who in the hell do you pick to attribute that potentially avoidable hospitalization to?

Reassure me that my interpretation of where you're going with this is correct, that you're using it for regional variation comparisons and not thinking in terms of nailing a potentially avoidable hospitalization on an individual as part of their performance evaluation.

MS. MILGATE: We have only, yes, used it at the MSA level. We've actually been discussing that very issue with an expert panel we pulled together to advise us on these very topics. And had a discussion actually on that exact issue in our last meeting.

There were actually varying opinions on that with the one physician on the panel suggesting that well, physicians did have some role, and others saying exactly what you're saying, that perhaps it's not something you should hold an individual physician accountable for.

DR. NELSON: I think you could but it would depend on the condition. You'd have to be very selective in terms -- and if there's a potentially avoidable hospitalization based on whether or not you treated a pneumonia in the outpatient setting appropriately, that would be an example where yes, you should assign credit or discredit.

MS. MILGATE: So you think that it's more specific to the condition which would argue against combining them.

I'm not sure because we haven't looked at the data, but given what we found at the MSA level it seems like it would be difficult at the individual physician level to get enough sample size on the potentially avoidable

hospitalizations by condition. So we were thinking of looking at -- and I don't know exactly what we'll find -- combining them altogether at the 100 percent to see what we find.

But your caution is definitely in play about then suggesting that this is a measure you should actually hold individual physicians accountable.

DR. NELSON: Yes, I think you would have to consider the degree to which a chronic condition that extends over a long period of time -- I mean the amputation on a diabetic is an example. Who do you blame when that person has had this condition for 20 years?

MS. MILGATE: Okay.

DR. CROSSON: I think I have two impressions and a question. The first impression was it seems that there's more here than I might have thought anyway when we first started down this path. And this may be a lot more useful than some of the other avenues that we've been exploring.

The second one, in connection with Alan's comments, is that it's probably more complex than it might have appeared to be and that we're going to have to spend some time on the modeling assumptions and that perhaps even

think it through -- I hate to say this -- but think it through almost on a disease specific basis to make sure that the logic works for the collected clinical conditions. Because they may, in fact, have different drivers, different logic behind them.

The question was, in terms of separating the resource use from the process quality measures, is it conceivable that you could take the resource use required for the process measures out of the resource use denominator? Trying to separate inappropriate from appropriate resource use.

In other words if you extracted from the resource use denominator, let's say mammography screening, the resource inherent in mammography screening, et cetera, and then did the analysis would that help to pull apart --

MR. BRENNAN: I think it would be a little difficult only because then you'd have to make some assumptions regarding what an appropriate level of care was and then that starts -- I mean I know there are benchmarks and clinical guidelines for certain conditions. But then you get into the every patient is different and this patient needed two of this instead of one of that.

I'd be a little hesitant, but...

MS. MILGATE: Beyond the technical issues which, as Niall expressed would be difficult, I don't know that you'd see anything difficult because what many of these quality indicators measure are pretty small dollars. And so the pattern is more if in a particular -- at least this is how I'm interpreting it -- in a particular MSA physicians are just generally doing more, they're just potentially doing generally more of the stuff we measure for quality indicators as well as everything else.

So if you took it out I don't think you'd see a real different pattern because they're not expensive and because they're probably just going to be doing more claims-based process indicators.

It's not like you're not measuring something that's real. They are doing more of the claims-based process indicators but it's unclear whether, in fact, the outcomes of those are as good on other measures.

DR. REISCHAUER: First of all, let me congratulate the two of you. This is really a tremendously interesting analysis, and I think sheds light where there's been darkness, at least outside the halls of individual health

plans that have done some of this kind of work.

Karen, you talked about creating these composite scores and the two different weighting mechanisms, the simplistic average and the opportunity-based one. But what worries me about weighting systems is we really should be weighting by clinical significance or financial importance to Medicare. Even in your opportunity-based one you're taking some things which we think are indicative of high quality but they're really small throwaway items and others which are life and death, and sort of saying they're of equal importance.

Is there any way we can sort of move down the track of developing weighting systems that I think are more reflective of what really is important?

I mean, there's a tendency in all of these weighting systems to pretend if we just do a simple average, or even the opportunity thing, we aren't weighting. But in fact, we are weighting and we're weighting in a way that is really bizarre when you sit down and think about it from the standpoint either of fiscal resources or significance to health outcomes.

MS. MILGATE: I have a couple of thoughts.

DR. MILLER: That's all I have. too.

Here's the good thing. We knew someone was going to ask this question and we talked about it among ourselves and we don't have a very good answer for you. One of the things I almost was going to say in the presentation is when Karen was going through and saying I'm putting these composites together, this is not to say that we forgot -- I know. I know. We had this conversation among ourselves. We know that this issue has surfaced. And you have spoken to it very directly and very strongly, that this may be more important than that.

I think that this is one that -- and so we're doing this just as an exercise to kind of go through and really just kind of feel our way through the data. I think you have raised the question and it may be that we just have to define that as a project in and of itself to crank through as we go down this track. I think you'll continue to see exercises where we're saying take a look at this analysis, we're just trying to get a feel for it, but we're going to have to approach that question.

And I really don't know the answer, and I think Karen, we've had conversations about this. I don't think

there's a lot of consensus out there and I think a lot of people come back to simple averages because there isn't a lot of consensus.

MS. MILGATE: Just to add a couple of things right off of that point, we have again talked to quite a few people about how do you do it. Actually the most sophisticated example that I know of is a process AHRQ went through to figure how to develop composites at the state level. And they had some that they did averages simply because there was too many component moving pieces and some that they thought were really more appropriate for the opportunity model.

Then I can't remember if they also perhaps had some weighting, the kinds of factors that you're talking about.

But many of the projects actually use some of those criteria to decide even measured in the first place. So if it's an important conditions to the population, if it's high dollars that might actually cut off some of what you might look at in the first place, and then after that do more of their well, are you going to do a straight average or not?

Specific to -- and I think Mark's right, that it's really a bigger issue and it doesn't mean we shouldn't take it on in this project or think about it, but that it may need to have a broader look because we need to look at it for hospitals as well, for example.

But in this particular analysis on these indicators, just looking at the necessary care indicators, I don't know that the problem is quite as large because they're not outcomes. They're all basic services that should be provided. You could say some have more bang for the buck than the others, but in fact they're I guess a little more even than some of the sets that you see in part because they're a limited set.

I don't know in this analysis if I would be as concerned if we're primarily looking at the necessary care.

MR. HACKBARTH: Arnie, you have a comment on this particular issue?

DR. MILSTEIN: On this point, having been down this road on the private sector side, I know it's tempting to weight clinical process measures for their impact on outcome.

One of the things I can report back is you do run

into some of the problems that Peter Neumann articulated at our last meeting where almost all advocated process measures do have -- they are advocated because there is some evidence they impact outcomes. But when you then look at the outcomes that they've been shown to impact, what you find is sort of a non-uniform currency on which they're measured.

I mean ideally they'd all be measured on impact on quality adjusted life years, ideally for the Medicare population. But when you get to the end of the road for most of these process measures what you find are facets of favorable outcome that are not easily compared. And I think there, as Peter Neumann was suggesting last meeting, there are things we could do nationally to begin to address that issue.

And I think that this suggestion would then less be valuable because even with the imperfect information better to have weighted process measures than proceed on the assumption that they're all equally valuable. But at the end of the road it's unfortunately a little bit murkier than we want it to be.

DR. WOLTER: I agree, this was very well done and a complicated work and was not light reading either.

It got my wheels spinning in quite a number of directions, and in particular connecting the dots to some of the other work we've done around coordination of care. I noted that there were some high attribution episodes that tended to be around things like hypertension and Type II diabetes which got me thinking about some of the Alan's comments in exec session yesterday and are there areas where we can identify that it makes a lot of sense to create attribution and ultimately accountability at the individual physician level in terms of coordination of care? Whereas as we moved into the high hospitalization dollar areas attribution was more difficult.

I think that that's where, if there's an implication here that we're going to be able to ultimately tie most episodes to an individual physician for accountability, I think given the fragmented underlying delivery system that's going to be unlikely in the long run.

I was even wondering if case studies, because one-third of E&M codes means there's a lot of care being provided outside the province of an individual physician, would a few case studies to see what is the actual relationship between that physician who has one-third of the

E&M codes to the rest of care that's provided? It may be that there's not much coordination or relationship between that physician and all of the other care that's provided, particularly in the high hospitalization areas.

I think that when you look at the chapter on coordination of care and care in a couple of models you proposed for those more complex high cost patients, clearly some approach to the organization of care has to be put in place. And ultimately, in looking at attribution, do we also want to incent that accountability is placed more at a team level for some of these things in addition to finding those places that Alan pointed out yesterday could be placed at the level of the individual physician?

I think it's going to have to be both or we really won't tackle the problems of accountability that can successfully take care of complex high-cost patients well.

It really got me thinking about that because ultimately we are trying to find a way to create some accountability to create improvements.

I also think that the claims-based quality measures can only take us so far. Some of the key quality process measures just don't come off of claims. As we have

looked at trying to tee up with the voluntary physician measure reporting, we found that many of the measures we really did have to go to chart reviews for and that sort of thing. Many physicians have commented too, that for them to comply with these measures really requires does the hospital they work at participate in collecting some of the measures, depending on the disease state. Which again points to the issue of at some point, with the more complex patients, creating incentives around how the delivery system is organized is going to be important.

I'm probably jumping way ahead of the game. We have a lot of work to do on this data to start with. But I don't think the end game can be that we find a way to attribute all complex cases to one physician. I just don't think that that's going to be successful.

MR. BRENNAN: Just very quickly, I think that's a very good point. And where we've been going internally, I don't know if it actually made it into the paper, but there may not be a one-size-fits-all approach to attribution. For certain conditions you might want single attribution with a 50 percent threshold for other conditions. You might want multiple attribution with a 30 percent threshold. So we're

still exploring that. As you pointed out, it does differ a little depending on whether it's a chronic condition that doesn't have a lot of acute care usage versus a condition that has a lot.

DR. WOLTER: To be real specific, over the last couple of years we've had presentations that have come at us from different places, even the insurance industry, that has pointed out that ultimately creating accountability at more of a group level may be necessary for certain high cost complex issues. And that's really one of the important themes, I think, that we could connect to this eventually.

MS. BURKE: Just on this point, following up on Nick's comment, one of the things that occurred to me around the issues of attribution is the extent to which the change in practice, the development of the hospitalist for example, and the movement to essentially transfer authority over a patient during periods of time, during limited periods of time, whether that will add to the complexity of ultimately tracking and dealing with this question of attribution. Who ultimately is responsible for decisions and certain kinds of behaviors?

I do think it will vary by condition potentially.

And so whether it's a percentage of whatever it happens to be in terms of trying to figure that out, I think Nick raises a very good point. I think it is going to become more complicated rather than less as these sort of methods for delivering and the site of delivery and whether it's a team or not come into play, I think will vary by condition.

So I think the point you make, Niall, is that it may not be a single method that applies to all, I think is exactly right.

MR. HACKBARTH: I think the point that Nick made is a really important point and raises one of the basic issues facing not just Medicare but the broader system. Does organization drive payment? Or does payment drive organization? There's sort of funny very important interaction between the two.

We've got a fragmented delivery system, in part because the payment system reinforces that, tolerates it, accommodates it.

Now if we say well, we've got a fragmented delivery system, we have to continue to pay in ways that reflect that, we will always have a fragmented delivery system.

On the other hand, if you have a payment system that is totally disconnected from the reality of practice, it's a nonstarter politically, and in a lot of other ways. It's a very difficult problem to get out of.

MR. MULLER: Just briefly along those lines, the chart that we had on five, which shows not a total consistency, as you pointed out in the elaboration of the Minneapolis and Miami example, in terms of practice style and patterns, and we all know that's true inside settings as well, even in a complex place like ours. You can't necessarily infer at a certain place in cancer therapies what that means for cardiovascular or neurosurgical.

I think it's important in terms of the weightings that we also keep trying to remember, in terms of the comments earlier about the financial aspects of this, what proportion of the total delivery system is measured by these various conditions. I'm trying to remember from last month, when you start adding up especially coronary artery disease and congestive heart failure and diabetes, I'm trying to remember the number you had of what proportion of Medicare spending you captured by those three. I don't know if you

remember off the top of your head?

MR. BRENNAN: Off the top of my head, I don't remember but it's a pretty sizable chunk.

MR. MULLER: Wasn't it pushing 60 or something?

DR. REISCHAUER: 61 percent of the inpatient.

MR. BRENNAN: I guess there are different things. For CAD, 61 percent of CAD dollars are inpatient dollars. Is that what you mean? Or do you mean of our selected episodes how much of Medicare spending did they represent?

MR. MULLER: The latter.

So obviously the inpatient is perhaps more clustered. But if one goes down the attribution argument I think one would want to look at our we covering 40, 50 percent of the care provided, to Nick's point, in a delivery system, in some kind of responsible unit? Or are we just looking at a low number, 10 percent? Because obviously the extent to which you do a lot of measurement of 10 percent, 10 percent, 10 percent, you may decide you want to add them up. But it doesn't tell you a lot if you add them up if you're very superior in one area and inferior in another area.

So I think these questions of how much of the

total care are we measuring, and as you pointed out in your response, what one measures on an inpatient scale can be considerably different than what one measures on the physician scale if you look at four or five conditions.

So I think thinking a little bit about what we're trying to get to in attribution -- I mean one of the discussions we had going back two or three years is what kind of accountable units are we looking at? And a lot of people around this table have, over the years, argued for bigger, more organized systems.

And to do that I think it's helpful for us to keep reminding ourselves whenever we're looking at this kind of analysis what proportion of the clinical pie are we looking at?

Just the fact that the physician -- if you add up these conditions as to what proportion of the physician services there are, if they are considerably different than the proportion they are of inpatient services, one goes in different directions. As some people have said the weighting of how you weight this, what proportion of the clinical care you're looking at, is I think of major importance.

MS. HANSEN: I just want to preface that this is probably even a further stretch but it has to do with not even large organized systems but to take some opportunities to use -- perhaps some of the findings from all the PACE sites that do have both an organized delivery system, as well as an integrated financing system and take a look at some of these conditions that are not just singular, since the average elder person has about eight diagnostic conditions, and perhaps take a look at some of the data sets because all of the ICD-9s are collected on that.

Going back to the whole attribution of accountability, the unit of accountability is actually the whole provider. With a physician you can cull out obviously the diagnoses. But the distribution of services which moves beyond unfortunately Medicare, but when you're dealing with this population there are other services that come in oftentimes on the Medicaid side. But to be able to just understand the patterning and the diagnostic coding that comes about with this kind of comorbid population that goes perhaps with all three categories and taking a look at the cost elements that come out.

MS. MILGATE: When you say they're collected, the

ICD-9s, in what way?

MS. HANSEN: They're submitted to Medicare.

MS. MILGATE: They are, so even though they get a capitated payment, they keep track of their claims?

MS. HANSEN: Yes, so all the claims are there. So the practice patterns can then be looked at relative to about 35 sites across the country.

DR. MILSTEIN: A number of the measurement issues that have been raised over the last few minutes have come up in prior similar efforts over the last few years, NQF, IOM, et cetera. Let me just sort of share a few insights that I pulled from those activities.

First, one of the things that you realize is that there are multiple windows that are equally valid with respect to individual and group, for example efficiency measurement. And in some cases, they are related to what condition you're trying to evaluate.

So even something as narrow as a per visit cost might be the right longitudinal unit of accountability for a physician's management of a cold, a patient with a cold, whereas for a broken arm a per episode framework intuitively makes more sense. And for congestive heart failure maybe a

year's worth of illness makes more sense as a denominator, or even two years as others have suggested.

The second insight that one pulls out of -- at least I pulled out of these discussions -- is that there also can be multiple units of accountability for the same measure. To say that, for example, a complicated asthma patient it's not reasonable to hold a physician accountable for that, I think that's absolutely true. One appropriate unit of analysis for a complicated asthma patient is not just the physician but the group of physicians and other team members that are involved in managing that patient.

But that said, holding team constant, there is such a thing as better performance, better results by some physicians within a group than others. And we don't want to lose that signal and that basis of performance distinction.

Let me now jump to a related topic but a different topic, and that is that over the last three or four years the private sector has satisfied itself that there is a reasonable ratio of signal to noise on physician efficiency measures and has, in some ways, put their money on the line. That is you now can find in a variety of places around the country insurers who, based on physician networks that

they've narrowed, based on efficiency measures, or that they've tiered based on efficiency measures, they now are able to offer the public a significantly lower premium associated with networks that have been narrowed or tiered based on these measures.

Now if actuaries -- and John can override me on this -- but if actuaries are willing to bet on this and bet their careers on this, and indeed in subsequent years this has turned out to be a good bet, that tells me that there is signal here. This can't purely be due to unaccounted for differences in patient morbidity if, after narrowing the network based on these measures you get a substantially lower PM/PM and curl.

That said, many private payers struggle as they attempt to assess physicians on the efficiency measure but also on the quality measures with borderline levels of claims experience with an individual physician. I think both of these two facets of physician performance, both effectiveness and efficiency, which are the two domains that have been presented today, could be much more effectively rewarded by the private sector if the private sector was able to boost their claims experience with individual

physicians via access to the beneficiary anonymized version of the Medicare claims database.

I think this week's New York Times editorial, speaking in favor of this as a Medicare policy option, I think was well argued and I hope it's something that we would consider here at MedPAC.

DR. CROSSON: Just one last comment Glenn, going back to your chicken and the egg analogy. I think we've talked about this once or twice before. But if you think about how we could see over time evolution of delivery system into more accountable organizations, the question is what could bring that about?

One thing that could bring it about overtime is the performance measurement process. So for example, the issue of attribution, I think, over time could convince at least some physicians and hospitals that rather than be subject to something that they may view as unfair that it would be better to be part of an organized system.

And secondly, to the extent that over time the measurement process uses information that either has to come from charts or from clinical information systems, to the extent that it's easier, more accurate, more efficient to

derive that information that is needed to be reported, for example, if you were going to do it that way from a clinical information system, and developing that capability is easier as part of an organized system, then the management and the performance accountability process may be a driver.

So I think as we go about this it might be useful to think about that. And perhaps, and I've said this before, even mark out that that goal -- that is greater organization of the delivery system might, in fact, be an explicit goal over time of the performance measurement and accountability work.

DR. NELSON: I'm not sure how much of the IOM deliberations are confidential but I feel comfortable in identifying a point that I made because I've made that point in other arenas. And that is that restructuring becomes feasible if the rewards, if the awards for doing so are substantial. You don't have to have a stick if you've got a big enough carrot.

The incentives for solo and small groups to get together and form virtual groups to pool their resources so they can afford the information technology to do the kind of reporting that allows resource use and performance on

quality indicators to be easily obtained. They don't have to be a group within one wall. They can be a virtual group tied together by information technology and pooling resources so they can hire ancillary personnel and so forth.

It seems to me that the natural resistance and inertia within the system, and it certainly is present in health care more than many systems, we have an opportunity to help break that down if we are fairly forceful in urging the kind of incentives that can make it happen.

MR. HACKBARTH: I think that you probably need a mixture of the carrots and the sticks. I could imagine that you might say okay, we will provide certain tangible benefits, rewards, that will draw people into more organized forms of care. They'll say oh, I'm maybe only going to be eligible for that reward if I'm in a certain type of organizational framework, or at least I'll only have a reasonable chance of obtaining that level of performance if I'm in a more organized system.

If you finance those rewords and you keep the whole system budget neutral by saying okay, that means we have to constrain payment for people who aren't producing that level of performance, you've got negative pressure on

one side and positive opportunity on the other. To me that's the broad direction we need to move.

Obviously the rub is where do you start? What's the magnitude? And those are the issues we're wrestling with.

DR. KANE: I just have a quick question, actually.

Pharmaceutical data is not in this yet. What's the timing on when it might be includable?

And then are the private plans producing date in such a way that it will be easily incorporated into these kinds of things? I just wanted to know more about how the pharmaceutical part might come into play, because it seems on some of these conditions that's going to be fairly critical.

DR. MILLER: Let me bounce the second half of the question to you. My sense is that the private firms do use the pharmacy data in these things now. Right?

MR. BRENNAN: Yes. And for certain episodes pharmacy costs can be -- like diabetes it can be about one-third of the cost of a diabetes episode.

DR. MILLER: I think it's going to be a while. If you consider that the claims data for that drug benefit have

just started on January 1 -- and I'll take any kind of advice from anyone on the staff -- but I'm thinking we're not going to start seeing that into well into next year, would be my sense, that there will be some lag. We might be able to see things sooner.

And then to move it into this process, we have to work through this as well. I think this could take a while to show up.

DR. KANE: Is the sense that before you have that information you would want to start using this as a payment incentive or performance measurement device for payment purposes? Or are you going to wait until you have the pharmacy data before you -- or I guess it's more of a question. Should the pharmacy data be in there? Because to me that's fairly critical to some of these conditions that we're looking at in terms of how well a patient is handled.

DR. MILSTEIN: On this point, and Karen maybe you can fill in here, I know that the leader in the research community in physician efficiency research, Bill Thomas, has analyzed whether or not -- appreciating that pharmacy is a significant percentage of total spend -- but he has taken a look at whether or not the deletion of pharmacy claims

significantly affects physician ranking.

And correct me if I'm wrong, but I believe that his conclusion was that it did not.

MR. BRENNAN: I'm not entirely sure. He actually gave me a draft paper the day before yesterday that I haven't had a chance to read yet. The points I do remember is for certain conditions like AIDS, pharmacy costs are a huge, huge component. And I'm not sure, he also did a paper recently that said that using risk adjustment didn't affect relative physician ranking. So I'm not sure if he also found that the inclusion or exclusion of pharmacy costs affected the rankings.

DR. MILSTEIN: This is knowable.

MR. BRENNAN: We can check that and get back to you.

MS. HANSEN: Just as a follow-up when I brought up the data that's available, and I've left On Loc PACE as of about a year-and-a-half ago. But we actually had collected both diagnostic and reportable to Medicare. Plus we have collected all of our pharmaceutical data, as well, online. So we have even as a small base.

Again I'm not in an authority position to offer

that you directly, but I can certainly make that connection for you. But we do have it all online so that it can be pulled out.

DR. REISCHAUER: But you're saying you have diagnostic data for individuals. But if it's not tied to cost information --

MS. HANSEN: But we have cost information, as well. We have cost, we have pharmaceuticals, we have DME. But again, it's a population of about 1,000, but we've tracked them over 12 years.

MR. HACKBARTH: Okay, good work. Thank you very much.

Next we turn to inpatient resource use.

MS. MUTTI: This presentation focuses on our framework for considering hospital efficiency and, more specifically, hospital resource use. Our goal in pursuing this topic is to see whether there is a way to hold hospitals accountable for both the quality of their care and the resources used to deliver that care, so that ultimately we can encourage greater efficiency.

We introduced the framework back at the November meeting but wanted to come back to it so we could get more

specific feedback on a design issues as well as any additional general thoughts you have on our overall framework.

This slide may refresh your memory about the framework we presented in November. As you can see we consider hospital efficiency to be a function of both quality and resource use. As you might recall at the last meeting, Sharon broached the subject of quality measures as well as the challenges of creating a composite measure.

On the side of resource use we have begun our work by identifying three distinct yet complementary dimensions. The first are hospitals costs during an inpatient stay. This refers to the costs incurred by the hospital in delivering care that is paid by Medicare under PPS. Hospital costs are influenced by their propensity to use ICU care, the patient length of stay staffing decisions and other factors. And although Medicare does not spend more in the short term if hospitals use more resources of this type, over the long term hospitals collective cost growth increases pressure for higher annual updates for Medicare.

Our second dimension is the volume and intensity of care around an inpatient stay, particularly physician

visits during the stay as well as all other care after discharge. Our literature review suggests that hospitals are in the position and often do influence care during this period, and I'll elaborate more on this in a minute.

The final dimension is the propensity of physicians on the hospital's medical staff to admit patients. Some hospitals have physicians who choose to treat on an inpatient more readily than other physicians. Hospitals can influence their affiliated physicians' admitting practices by, for example, offering outpatient and chronic care management services then prevent the need to hospitalize, as well as by maintaining a bed supply that is well-matched to the community's need. As we discussed yesterday, physicians tend to admit more if there are more beds available.

For the remainder of the presentation I'll focus on dimension two, the volume of services around an admission. Hopefully this diagram will help clarify our concept. As you can see we are on a time continuum, as the line at the bottom indicates. This box here represents the hospital stay itself, which reflects dimension one, the hospital's costs during the stay.

Dimension two specifically refers to the physician visits during the hospital stay as well as care after discharge. That includes physician visits, post-acute care such SNF and home health care, outpatient visits and readmissions.

In the next three slides I'll discuss the possible motivation for measuring this dimension. Fist, I'll discuss whether hospitals can and do influence Medicare spending on other health care services. Presumably, it is only worth holding them accountable if, in fact, they can influence that care. So what are their opportunities and constraints?

Second, I'll briefly review the literature on variation in Medicare spending and care patterns around an admission. The logic here is that to the extent that there is variation with no differences in quality, there may be room for resource conservation.

Then I will switch gears a bit and address one of the central questions concerning how one would proceed measuring this dimension, and that is how long an episode could a hospital be held accountable for? Are hospitals able to influence care just during the stay, a short time afterwards, something like 15, 30, 60 days? Or are they

able to influence care even years after the admission?

Research findings suggest that hospitals are able to influence resource use, as I mentioned earlier. Among the prime leverage points are their ability to control complications and infection rates. Success in this area means fewer intensive services during the hospitalization as well as fewer readmissions and other post-discharge services.

Managing the transition home is another way that hospitals can influence episode spending. I'll give two examples here so that it also illustrates sort of the merging of that care coordination issues that we've talked about as well as resource use measurement.

One example is a hospital found that it was able to increase appropriate use of medications known to prevent complications if a checklist of medications was reviewed by nurses just prior to each patient's discharge.

Another hospital found that by having nurses repeatedly meet with patients at high risk for poor outcomes after discharge, patient needs were better met and readmissions reduced. Home visits were scheduled 48 hours after discharge and seven to 10 days after discharge. Those

who needed more received more. Visits were also made during the hospitalization.

The nurses provided written instructions and medication schedules, addressed patient and caregivers questions and interfaced with physicians to obtain needed services and adjustment to therapies. The result was a 62 percent decrease in the readmission rate after six weeks of the study.

A hospital's culture and work environment also seem to matter. A recent study that looked at physicians practicing in two different hospitals found that physician's patient's length of stay, after controlling for differences in health status, varied depending upon which hospital the patient was admitted to. This suggests that a physicians' judgment about length of stay, a key aspect of practice style is not uniform or constant but instead is influenced by either colleagues at a given hospital or that hospital's management approach.

As several of you commented in November, the opportunity to influence care may vary among hospitals. Factors that potentially constrain hospitals are their relationships with physicians, affiliated physicians, the

culture, the presence of competitors in the marketplace, and financial arrangements between hospitals and physicians, for example, may influence whether some hospitals are able to positively influence the care after discharge.

Since physicians are the ones performing the surgery, signing discharge orders, prescribing drugs, their cooperation is key.

Another constraining factor is the uneven diffusion of clinical IT. Hospitals that have invested in clinical IT may be in a much better position to identify problems such as complications and then implement effective interventions.

Uneven supply and mix of health care services and professionals is a third potential constraint. For example, the mix of post-acute care options varies across markets and we might want to be mindful of that.

On the question of variation, research shows that there is wide variation across hospitals in the number of services provided around a given type of hospital stay. Again, this is important because variation suggests that there is a possibility that resources could be safely conserved.

Some researchers have focused on variation in the volume of physician services provided during the hospital stay. They found that, after adjusting for price and case mix, payments to physicians for inpatient care per admission ranged twofold across MSAs.

Other research has looked at variation in resource use six months to five years following the hospitalization in some 300 hospitals. That study found that Medicare spending on hospital and physician services in high intensity hospitals was 11 to 16 percent higher than in low intensity hospitals six months after discharge. Over the five-year window that it looked at they found wider variation, 49 to 58 percent higher spending in some hospitals than others.

Another study found that patients in the last six months of life getting care from the seven best hospitals for geriatric care, as rated by the U.S. News & World Report, received very different amounts of care. For example, the number of physician visits was more than twice as high at Mount Sinai Hospital and UCLA than at Duke Hospital.

Now to our design issue. How long an episode

could hospitals reasonably be held accountable for? As I mentioned, it could run that spectrum from none to just a little bit after the stay to years after the stay. This question challenges us to define the notion of longitudinal efficiency. How encompassing should our longitudinal measure be? We hit on this subject in the last presentation, too.

The answer may depend on the degree of responsibility that you think the hospitals should have here. For discussion, I'll offer three examples of different degrees of responsibility and the implication of that responsibility.

If you think that the hospital's responsibility should be limited to its role in direct patient care and its consequences only during the stay, then the hospital could be held accountable only for the stay.

If, on the other hand, you feel that the hospital's responsibility extends to the direct consequences of its care, such as the complications and the infections that I talked about before, as well as the efficacy of its discharge plan, as well as the type of culture that it creates in the environment, then a hospital could be held

accountable for care delivered immediately after the stay.

And lastly, if you think that hospitals should have a responsibility as conveners of physicians influencing them both in their hospital-based care as well as in their office-based and primary care, then a one to five year window may be appropriate. The longer episode here addresses also the propensity of the physicians to admit, which we also try and pick up in our third dimension that I discussed earlier.

Each of these approaches entails a host of policy and logistical questions. How do you align the incentives between the physicians and the hospitals so that there is the cooperation that we need? How do you risk adjust appropriately? A whole range of questions. But at the moment we were hoping to get your feedback on this broader question.

So with that, we look forward to your comments.

DR. WOLTER: I suppose you could cut my comments from the last section and paste them into this one. But I do think that we should be thinking more about what is the accountable unit. And just to connect the dots again, if 61 percent of inpatient costs are related to three diagnoses,

either alone or in combination, there's a tremendous amount of gain to be made by tackling those areas where we also know the quality measures are not adequate.

And so the whole issue of coordination of care, I mean one of the IOM's key principles is patient centered but we're proposing hospital-centered and physician-centered approaches to accountability, whereas if we're looking at congestive heart failure or diabetes clearly the appropriate time is not four days in the hospital or 30 days after. It's a year or two, or whatever the case may be. And if we were to design incentives that took a little of Part B and a little of Part A and said for the appropriate physicians in hospitals that want to work together -- these could be formal groups, these could be virtual networks as Alan has pointed out. But we will take accountability for the care of these patients and the costs of these patients. Then we can design ways of looking at the care of these patients that go beyond just the hospital stay or just the care in the physician's office.

And then if you connect some of the other issues we've dealt with over the last few years, the diffusion of IT is very critical to this. And yet there clearly are

barriers now to hospitals and physicians putting the same IT systems together. Some of those have to do with Stark and kickback regulations. The gainsharing that we recommended in the past could come into play here if we really wanted to look at how we tackle this in a different way.

So I hope we can maybe try to bring some of this thinking into these chapters, even though you're right Glenn, it's the chicken and the egg. How do we build this on top of what we have? But on the other hand how do we create some direction where over five or 10 years we might end up in a different place?

MR. MULLER: My comments are along the lines of Nick's, so I won't repeat his excellent exposition of them.

The question of the payment incentives, just to build on one of them, obviously if the big payment incentive right now is inside the inpatient episode, in those three or four or five days, there are not payment incentives right now in the same way to take care of the care after the hospitalization except insofar as there's a complication that causes somebody to be readmitted, and so forth. So how one thinks about payments have to be changed within a more bundling approach, as I think is what Nick was suggesting

there, is obviously a critical part of this.

Also in terms of point two, on the accountable unit, in some ways in the Modernization Act it strikes me there's a big policy statement there that the accountable unit becomes the health plans. And so the kind of innovation that will go on inside those health plans and their relationships to doctors and hospitals and so forth is a critical thing for us to keep watching because I think, in many ways, that was the philosophical statement as I read it in the elaboration of Medicare Advantage.

So the extent to which that becomes a set of accountable units that then works with the hospitals to get that kind of longer-term longitudinal responsibility for care is something I think we should keep watching. Because in some ways it's not CMS as an agent, sitting here in D.C. or Baltimore. That's going to be individually doing all of this with all the hospitals and the physicians of America strikes me we've made a major statement that it's going to be the health plans who are doing that.

Like Nick and Alan and others, I think we should keep focusing on how to get organized delivery systems more incentivized to be created. As we've said, that Jay's had

one for 50-plus years, we need to keep evolving in that kind of direction.

But right now I would say, in terms of MedPAC, having the payment system more fully reflect what we want to do in terms of accountable unit is an important thing for us to do because right now we have all of this evidence that the payment system cuts against the kind of themes that we're stressing.

DR. MILSTEIN: Outside of the HMO environment one of the interesting phenomena over the last 20 years is no one wanting accountability for either longitudinal cost or longitudinal quality. It's sort of like -- if someone were here representing health plans, they would say no, not me, it's the hospitals and the doctors. And Nick is saying no, it's the plans.

And that's the problem is that you have -- okay, sorry. I really think that returning to this notion of multiple units of accountability for the same outcome is the only solution in a non-organized system of care on a prepaid basis.

And so I think I yes, for longitudinal both economic and quality outcomes, the plan has to be

accountable. But so does the physician group, the individual physician, and the hospital. And we need units of measurement and forms of accountability at each of those levels. Because they all can have a significant influence on longitudinal both cost and quality.

Let me go down to a very narrow point now and ask -- one of the facets, if we were just looking purely at a relatively narrow inpatient unit of analysis, thinking either way on the inclusion or non-inclusion of prehospitalization for elective admissions, prehospitalization work-up activities, that can obviously unfairly reflect upon a hospital if those are done on an inpatient basis. Yet they are part of, certainly for surgeries, part of the necessary services incident to the surgery itself.

MS. MUTTI: I think we've thought about that. We just didn't tackle that first, in this presentation.

DR. MILLER: Arnie, some of the reason that we wanted to have this conversation and take this piece of the hospital inpatient or the hospital resource use is that there has been this repeated theme of longitudinal accountability that you brought up.

And so we're trying to get a feel, and I'm sure other people will comment. But from your perspective, if this was a tool that we were building and one that we're using, what is your sense? I don't mean to pin you down so much, but 30 days? Two years? Those are big differences. And I think hospitals could reasonably come back and say there's a big difference and my ability to influence a patient a couple of years out could be very limited.

So could you talk a little more about that? Because I think a lot of your comments are driving some of this question.

DR. MILSTEIN: I think per my earlier comment, the answer is for some conditions multiple windows, multiple longitudinal windows of measurement and accountability for, for example, a hospital would all be appropriate. That is there may be some hospitals that are truly distinguished on their Eliot Fisher, you know, initial hospitalization event and five years subsequent. There may be other hospitals that substantially outperform that particular hospital on this more narrowly defined window that we heard about this morning.

I think what's important would be for us to

essentially build out multiple longitudinal windows for a particular provider and recognize the fact that some providers may excel in some facets of efficiency. And others may excel at others.

I don't think there is any one -- there may be, for many conditions, no single unit of longitudinal -- single longitudinal frame that's appropriate for measuring efficiency. There may be multiple that are applicable.

MR. MULLER: But Arnie, the payment system gives you a clear answer. It's the stay only, is the answer right now.

DR. MILSTEIN: Today.

MR. MULLER: Aside from some bundling on the surgical side. So if you want the answer in the payment system, the answer is the stay. If you want to change the policy, as I said, then you need to have some modifications in the payment system to both pre- and post-bundle the stay if you want more longitudinal accountability. But right now the hospital basically, the payment in terms of the costs that go into the DRG, they end on the day of the stay except for some very modest exceptions.

DR. MILSTEIN: The consequences of only using that

window are ones that we're all familiar with.

MR. MULLER: Oh, yes.

DR. NELSON: I come at this from a little different direction. I think if we're talking about the hospital saying how long after the patient leaves do I get blamed for, that's one thing. If you're talking about the hospital saying how long after the patient leaves am I able to receive a reward for good management, then that's a different breed of cat.

As a long-term strategy, I think that we ought to have as a principle that we would like to break down payment silos when it comes to rewarding performance.

Now I'm suggesting that we break down the payment silos that pays for the services that are received. I'm saying that if we are talking about rewarding performance we ought to be looking at a commingled reward pool that acknowledges that hospital efficiency may increase as a product of outpatient, better outpatient management, both before the hospitalization and after the hospitalization. And that the reward pool should be commingled so that where the benefit is attributed gets adequately recognized.

This again is something that has had some

discussion at the IOM and other places. And I don't think that it is helpful to retain indefinitely independent silos of reward pools that ignore how interconnected they may all be when it comes to improving performance.

MR. HACKBARTH: I think that's been as clear a theme as we've had over at least the last couple three years. We keep coming back to that. I think that, in terms of vehicles Nick mentioned concerning that in some of these chapters and I think that's important to do.

I think potentially our report on the SGR is another important vehicle for pulling together some of these ideas in a coherent way, and at least pointing to potential paths to pursue. We need to get from the conversation, though, to a much more concrete level of discussion on this.

DR. STOWERS: I think my comments are almost redundant from Arnie to Ralph to Alan, but it initially struck me when I saw the physician visits during the hospital stay and after the hospital stay that it would be very interesting to track them back six months to a year prior to the hospital stay, which would show initial care for congestive heart failure, diabetes, that sort of thing. Because certain integrated health care systems the hospital

has a lot of responsibility in running that.

And I think the correlation between the hospital rate and whether or not they are being seen on a regular basis, getting what they need, I know some previous work has been done on that that was really pretty fascinating. So it might be interesting to do both pre- and post. And I think I've heard that here before.

MR. SMITH: I don't have a lot to add to what colleagues have said but a couple of things strike me.

Arnie, I think it's very hard to have complex overlapping intervals of responsibility without beginning with bigger episode defined bundles of payment. I think it will be the contractual relationship between the hospital and the post-acute care setting or the clinical relationship between the hospital and physician visits during the setting. That is where efficiencies as well as quality improvement can be affected by the hospital. We've got to somehow give them the capacity to utilize financial resources in order to try to drive those outcomes.

What we can't do is look back at a fragmented payment system and say now we're going to adjust payments for quality in an imputed time frame where nobody was in

charge during that time frame.

Outside of the coordinated system part of the delivery apparatus, I don't know how we get it without bigger bundles. I think Ralph described it correctly. We've tended to, and we do in the care coordination discussion and the post-acute section, we tend to focus on the post-acute stay part of the bundle. But Ray beat me to it.

An awful lot of what isn't getting done is not getting done in the pre-acute stay either badly or unmanaged physician and other practitioner services. And figuring how to get that back into the bundle, assuming we can't or don't want to put everybody into a plan setting, we need to go both board and backward as we think about what these episodes look like.

MR. HACKBARTH: I'm trying to pull together some of these comments.

Right now we've got our fragmented fee-for-service system. At the other end of the continuum we've got a complete capitation model. One approach to addressing some of these issues would be to create a third option which voluntarily allows groups of physicians and providers to

assume responsibility for broader bundles of care that bridge the Part A and Part B. If it's done on a voluntary basis I think we're addressing one of the issues that Alan has raised, the rewards versus it all being penalties. You can say you can stay as you are, but if you go into an organized relationship with other providers you may have an opportunity to improve performance, both quality and efficiency, and be rewarded for that.

Now conceptually that's easy to say. It's much harder to devise the policy. But that's one potential path that I hear us wanting to explore it. There are some other ways you can approach it as well. Bob?

DR. REISCHAUER: There's a problem with this and that is there are there the providers and there are the beneficiaries. And what's different about the coordinated care model, the Kaiser or whatever, is the beneficiary has said I'm going to be in this regime. That's the missing agreement when you go to virtual groups or other things because you then have to ask yourself does the beneficiaries still have the ability to walk, in a sense. That makes it more complicated because you then don't know how to attribute accountability to those who don't stay where they

started.

MR. HACKBARTH: That is a very important point.

DR. REISCHAUER: It may turn out that that's a very small situation.

MR. HACKBARTH: Politically it's a huge point, but in design terms it's a huge point. Are we talking about options within the free choice traditional Medicare and new paths there? Or are we talking about lock-in models?

I was talking about a free choice system but it raises the question of will providers step to the plate if, in fact, beneficiaries have the opportunity to go wherever they want?

DR. REISCHAUER: But you can also have the virtual group or the accountable group and the beneficiary voluntarily saying I'm agreeing to have this as my care management group or my coordination group, and give them some kind of an incentive, you know, smaller Part B, smaller co-payment, whatever.

DR. NELSON: Right, for identifying the care coordinator and staying with them.

DR. SCANLON: On this point, we have, in some respects, in the Medicare health support, something where

the beneficiary is being asked to participate without some kind of formal obligation. There is an organization that is doing something -- not quite a virtual group -- but trying to do something to bridge some of the gaps that we have. We may see from that how influential our organizations on beneficiary's behavior in terms of influencing their choices are.

DR. KANE: I'm going to sound like a broken record but have we thought about the fragmented Part D and how that will be brought into these incentives, and making sure that the formularies and the incentives and the drug benefit match the incentives in the payment of the primary care doctor and the hospital?

I'm just concerned that you've got a cohesive Medicare and then you've got this Part D out there that's privatized and fragmented.

So do we need to also be thinking about how do we make sure that the incentives are going on? And by what vehicles are those going to happened?

I don't think we can just keep ignoring that there is this other thing going on out there that I think has a lot of influence over certainly congestive heart and

diabetics are managed.

How can we make sure that -- is Medicare going to review the plans every year with regard to whatever you're trying to do with Part A and B or not? What is the integration and policy here? And have people thought about it? Should we be thinking about it? Because I just can't see this really working without having the whole package under some kind of single goal oriented system or it will get pretty complicated.

MR. HACKBARTH: It's an important point. I can imagine clinicians saying yes, I'm willing to step up to the plate to do this. And now you've got beneficiaries volunteering to do it. But now I've got six different formularies that I have to deal with as a clinician. That's another added complication.

DR. REISCHAUER: But in the stand-alone drug plan the stand-alone drug plan has no incentive to design a formulary or a cost-sharing agreement that saves money on hospitalization or something else. And so the real issue will be whether the MA PDP plans look a whole lot different from the stand-alone ones a few years from now.

MS. BURKE: The other thing, and this goes back to

Ralph's earlier point, I think one of the other areas of complexity -- and I've raised this drug issue repeatedly and I agree with everything Nancy has said. I remain deeply concerned that there isn't that type of anticipation or coordination going on.

But on the broader question of how one tries to move in this direction, I think Glenn is right that this ought to be a theme that we begin and have begun to state throughout a variety of our papers in terms of the desire to look at the patient throughout the entire period of their life, not simply sort of in an episode, which is what we have traditionally done.

But I think the issue that Ralph raises is exactly right, which is -- and this is not suggesting it's right. But the payment system in everything we have done has, in fact, encouraged these kinds of silos in a variety of ways. And we have tried to understand the silos more clearly and what goes into the silos.

In some cases you have more traditional relationships. The physician-hospital relationship is one that there is a history to and there is a partnership there that you could more easily imagine trying to get those two

pieces to work, although there are a variety of problems that arise and issues around gainsharing and a variety of other issues that we'd have to deal with.

But I worry that, in looking both at sort of the lead-in, the early as well as the late period of time of care, as David suggested, that it is at the end where there has been the least amount of collaboration historically in some respects. And that is with the sort of non -- I mean, the other institutional providers, the skilled nursing facilities and other partnerships that move on.

And we know that the experience with the discharge planning has been one of the great conundrums that we've not yet figured out how to manage, which is really making sure that there is great thought. I mean, it's sort of the tail of the dog. It doesn't quite get done right and there isn't the kind of attention to how important that is in terms of making sure that there are services available.

But I worry that that's where the least amount of relationship traditionally has occurred in terms of organized systems of care unless it is an organization that is completely controlled by the hospital, where they own the home health agency, they own the skilled nursing facility or

whatever it happens to be.

So I think again, as we look at how we expand that episode, I think that may be a very difficult thing to think of conceptually is how you force that relationship that has not existed. People tend to go long distances. They want to go closer to home, rather than if they're in an acute care facility they go back someplace else.

Those relationships might be the more difficult to manage in terms of trying to encourage or incentivize some kind of a partnership, potentially. I don't know the answer to that question. But it would seem to me that it is that broader group, as Ralph suggests. it is trying to get the beginning and the end, as David suggests. I think some of those partnerships are less easily understood or there's less history there than there might be in some of the areas.

MR. MULLER: Let me just speak to that. To paraphrase the old John Mitchell phrase, don't look at what we say, look at what we do.

We're basically spending a lot of time now in CMS in the new rule making the episode much more sophisticated, the re-weightings, but it doesn't deal with the coordination of care issue in that sense.

Excuse me one second.

MR. HACKBARTH: Pardon us while we say goodbye.

This is been a fruitful discussion but we are running behind time, so we're going to have to close it for right now. Thank you, Anne.

Our last session of the day is on outpatient therapy and Carol's going to lead us through that.

We are, right now, roughly a half-hour or 20 minutes behind, so I apologize for that.

DR. CARTER: This year we undertook a study of outpatient therapy. Program spending almost doubled between 2000 and 2004, yet we know very little about the value of this purchasing. There is little information about who receives services and no information about their outcomes. This makes it hard to evaluate program spending.

For example, we know that there are more users and that the average user received more services. We also know that there is a lot of variation in the spending per beneficiary. But we don't know whether the care needs of beneficiaries were increasing, and we have little information about the comorbidities of patients to know if spending was targeted at those with the greatest care needs.

Last, we can't evaluate whether increased spending resulted in better outcomes.

Today I'm presenting information about two approaches used by private payers and providers to manage therapy use that might be considered by CMS. I'll also outline what data are needed and how they could be used to design a new payment system.

We have discussed before the need for a new payment system that does not encourage therapists to furnish services. Combined with spending trends presented in January, this information will be a chapter in the June report, and you have a draft of that.

This winter MedPAC convened an expert panel and consulted a variety of experts to learn about and consider alternative ways to manage therapy use. We also asked the experts to evaluate the evidence basis for identifying who needs therapy and how much therapy is effective. We gathered information from over 40 people.

Of the strategies examined, two seemed promising for CMS to pursue: developing guidelines for practice and tracking resource use and patient outcomes.

Some payers and providers use practice guidelines

to approve continued therapy provision or to compare a therapist's practice to such norms. Service provision that is unusually high or low is flagged for review. The experts we spoke with had mixed opinions about applying guidelines to beneficiary service use. They differed in the assessment of the quality of the evidence underlying the guidelines but agreed that if guidelines were to be used they would need to be tailored to an elderly population.

Guidelines are generally written for a younger, healthier population and typically do not consider comorbidities and other factors that may increase the beneficiaries' care needs. If guidelines for the elderly were developed, CMS could use them to flag unusual service use for further review and to educate therapists and referring physicians about best practices.

Another promising strategy is the tracking and reporting of service use and patient outcomes and using this information to establish benchmarks. By comparing their own practices to averages, clinicians can reduce both the number of services billed during a visit and the number of visits. One integrated health system told us that it had lowered therapy use by 8 percent by tracking resource use and

patient outcomes together with standardizing their practices.

Another integrated health system told us that it uses vendor software to estimate the number of visits a patient is likely to need to improve and then pre-approves that number of visits. Using estimates of resource use and outcomes, the system focuses on ensuring that services continue to be beneficial to a patient.

Tracking resource use and patient outcomes is key to establishing practice norms and to evaluating program spending. In addition to flagging aberrant practice, benchmarks could be used to vary the therapy caps by patient condition. Spending limits could be lower for beneficiaries with modest care needs and higher for beneficiaries with extensive care needs. Limits that vary by condition would encourage therapists to be mindful of the amount of services furnished to all patients, not only the high end users constrained by the current therapy caps.

Private plans generally did not offer innovative approaches to paying for therapy. Most pay on a per service basis and limit the number of days or visits of care. One exception to this was a health system that plans to pay

therapists for the resource used and the outcomes their patients achieve. By comparing a therapist's practice to benchmarks, payments will vary according to the therapists' relative resource use and their patient outcomes.

To increase the value of its purchasing, CMS needs two types of information. First, it needs better information so it can accurately identify the care needs of beneficiaries. And it needs to gather functional status information at admission and discharge so that it can assess patient outcomes.

In this table I've outlined the data requirements and you can see that the majority of this information is currently not collected. To gather these data CMS must select a patient assessment tool that it would require therapists to use.

There are currently two functional measurement tools that can assess patients with varying clinical conditions and put all of these different assessments on a common scale. These are the Patient Inquiry tool and the Activities Measure for Post-Acute Care, the AM-PAC. Both been tested for their reliability and validity. The Patient Inquiry tool is used in many outpatient settings and has

primarily been used to assess patients with orthopedic conditions. The Patient Inquiry tool has a built-in reporting feature that links resource use to patient outcomes. CMS has explored the use of this tool at two clinic sites.

The AM-PAC was developed to assess patients across post-acute care settings. As such, it can assess patients with chronic and multiple comorbidities, including patients in nursing homes. HealthSouth has selected this tool to use across its post-acute and outpatient sites and Kaiser Permanente of Northern California is currently piloting the use of this site in a rehab clinic that specializes in neurological patients.

One advantage of the AM-PAC tool is that it can be used to assess the functional status of beneficiaries across the post-acute care spectrum. CMS is required to do a demonstration beginning in 2008 in which a common assessment tool must be used to assess patients across post-acute settings. If CMS decides use the AM-PAC tool for this demonstration, and then used this same tool to assess outpatients, it would be able to compare patients across the post-acute care continuum.

One way for CMS to test its selection of a patient assessment tool and to gather data quickly would be to conduct a short pilot. The pilot could test the feasibility of the data collection method from a representative mix of providers before all therapy providers were required to use it. In the near term, data gathered from the pilot could be used in many ways.

First, representative data could be used to develop and test an accurate risk adjustment method so that valid comparisons across patients can be made. CMS could also use the data to establish benchmarks for therapy provision and review aberrant practice patterns. As mentioned before, benchmarks could be considered for varying the therapy caps by patient condition. Also, better information could also be used to evaluate if the exceptions process is currently correctly identifying patients with high care needs.

Finally, the information from the pilot could be used to design a payment system. One option is to pay for a bundle of therapy services that varies by patient condition. Another is to develop an incentive payment system that encourages therapists to both provide high-quality care and

be conservative in furnishing services. Yet until better information is available, and adequate risk adjustment methods are available, efforts to design a better payment system will be hampered.

I'd be glad to answer your questions and take comments on the draft chapter.

MS. BURKE: This is really not truly a question, but it occurs to me, having just completed the conversation on this sort of broader approach to patients, whether there is anything as we look at this particular chapter or as we look at what kinds of tools ought to be available and information in terms of tracking the patient and anticipating their needs based on prior use as well as subsequent use, whether some thought ought to be given to whether there is a way to state this broader goal in the context of this chapter? And that is trying to understand the full nature of services and the collaboration that occurs.

I mean, as we look at the risk factors -- and the chapter is very well done in terms of looking at these issues -- in identifying what we don't know and how difficult it is to anticipate or to look at use based on a

variety of issues, severity and things of that nature, whether there ought not be given some thought to what our ultimate goal is and whether it should be reflected in terms of information that we want or tools that we need to develop.

DR. KANE: I have a question about whether it's also possible to tell who's providing the service? Because some states, I guess, have licensed therapists and others have these doctor's offices where the masseuse could be -- I mean whoever is in there, some states allow them to bill, too.

It would be interesting, I think, to get a sense of who's providing these services because the physician office, in particular, seems to be one of the fastest-growing areas. It is not really clear whether this is an extension of physician income, as opposed to a true physical therapy practice.

And I don't see any of the recommendation here that acknowledge that we should be trying to capture data on who's doing the actual services within the office.

DR. CARTER: There is a little bit of information that maybe I should highlight in the chapter. Therapists

need to be licensed in order to bill for services under Medicare.

Assistants can provide services but they must be supervised. It is very difficult in the claims data, when services are being provided in a physician's office we can't tell, first of all, which of those practices they are. Because if they are billing using a therapist's ID, we can't tell whether that therapist is actually practicing on their own or in a physician's office. The group ID just doesn't even tell you -- you can't tell therapy groups from physician groups. All we know is it's a group.

And so both the setting is really hard to tease apart. But also we won't know whether the therapist is licensed or someone being supervised. So there are limitations to what we can do there.

DR. KANE: I understand we don't know yet. I'm just wondering if we shouldn't recommended that that be part of what we collect --

DR. CARTER: A piece of information that we gather.

DR. KANE: Yes. Because your footnote here explains that you don't have any idea who's billing for some

of these things. And that's one of those areas where it could just explode with all kinds of people doing whatever, sports therapist and things like that.

MR. HACKBARTH: Okay, thank you, Carol.

We'll now have a brief public comment.

MR. MASON: Thank you Mr. Chairman. I know you're anxious to wrap up and a little behind schedule.

Dave Mason with the American Physical Therapy Association and we want to thank Carol and the staff for the Commission's efforts to explore the reasons for increasing beneficiary use of therapy services.

I think, as Carol just noted, there is little if any evidence available that indicates that the increased rehabilitation is not beneficial or appropriate for patients, and it possibly also reflects previously unmet needs or potentially more cost effective interventions. So I think those are all areas that you will want more information on.

The letter from CMS on the physician fee schedule that you reviewed yesterday refers to some of the improvements in chronic patient care and that is one of the areas we think you'll look further into.

We do appreciate the Commission's recognition to proceed cautiously in this area, especially in making changes in payment systems without a sufficient understanding of which services are appropriate to meet patient needs. And I think you've just have a good discussion about the concern that the codes that are commonly used by physical therapists are also commonly billed by many other providers and you don't have a lot of information on what's going on in that area, which I think you'll need to design a better system.

I'll point out once again also that APTA and the other professional associations have developed some guidelines and are working on practice patterns to assist therapists in both assessing patient needs and providing more effective interventions. Staff of the Commission has seen some of the work that we're working on there and we welcome the opportunity to talk more about those activities. We are working to develop and improve and standardize the collection of information of the type you're looking for related both to specific diagnoses and conditions.

We certainly support the idea that the staff report includes about additional research and piloting of

the assessment and evaluation systems and we would encourage you to consider APTA and the other professional associations as resources in that effort, a lot of expertise among our members who might be able to inform and assist in your activities.

So I thank the Commission once again for looking into this area.

MR. HACKBARTH: Okay, we are adjourned.

[Whereupon, at 11:02 a.m., the meeting was adjourned.]