MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 9, 2004, 10:31 a.m. *

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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ALAN R. NELSON, M.D.
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

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P R O C E E D I N G S

MR. HACKBARTH: Can I get your attention for just a second? We're going to wait a few minutes before we start. We're going to try to get some additional chairs and move staff people on this side so that we have more room for our public guests. And we'll just take a minute to see if we can organize that and get it done quickly. Thanks.

We're trying to get the chairs. If we can't get the chairs, our next step is that all of you have a copy of the agenda. I know you're all deeply interested in every facet of the Medicare program, but there might be some issues that you're more interested in than others. So our next step would be to do some triage and have people whose principal interest is not on the agenda this morning, if you could make way for somebody who really is dying to hear and talk about this morning's agenda. That would be our next step.

My understanding is the chairs are on the way and it's going to take a little time to get here. So I would

ask the staff as they arrive if you could move back here, get one and sit down, I would appreciate that. Because we're already behind, I hate to just sit here and wait an uncertain amount of time. So we're going to try to start and work through the addition of the chairs.

Before we turn to our first agenda item, let me just make a few comments to set the stage for the meeting today and tomorrow. As most of our guests know, our process is to consider draft recommendations at the December meeting and then have votes on final recommendations at our January meeting. In fact, that's what we will be doing today.

I want to make a couple of points about the draft recommendations that we will be considering. There are a lot of them, number one, 28 in total, which is going to mean that both the staff and the commissioners exercise a lot of discipline about presentation and discussion so we can get through all of the material.

It also, let me advise you in advance, could affect the amount of time that we have for public discussion depending on how the schedule goes. I will do my best to allow our usual amount of time for that, but given the volume of work required, it may be compressed a little bit.

The second point about the draft recommendations is that they are, in fact, draft recommendations. I would urge you to consider them as such, not over interpret what it is. In the case of the update factors, for example, all of the draft recommendations are, in fact, what we recommended last year. Whether we will end up in the same place or not I don't know. That's why we're having the meeting and having the discussion and that's what we'll figure out over the course of the next month.

The third thing to mention about the draft recommendations is when you look at it you may say this isn't a complete set of Medicare issues or even issues on which MedPAC has expressed a deep interest in the past. One notable example of that is Medicare Advantage where we've spent a lot of time in the past analyzing, making recommendations, developing a point of view. It is not included in the recommendations for the January report principally for logistical reasons. Because of the many mandated reports that we have to do, in addition to our normal work on the update factors, we simply did not have enough staff resources or time with commissioners to also process recommendations about Medicare Advantage. That does

not mean that we have lost interest and will not come back. In fact, we envision that we will be taking of Medicare Advantage again for our June report with discussions to occur about the issues and possible votes on recommendations to occur in March and April.

So the fact that it is not included does not mean lack of interest or lack of concern about the program.

That's the context for what we will be doing. First up is pay for performance.

MS. MILGATE: In this session we will be discussing draft recommendations that have come out of our past three discussions on pay for performance for hospitals, physicians and home health agencies. The central question of this analysis has been whether it's feasible, given current measures and measurement activities, to link a portion of payment of quality.

First, I want to just give a brief overview of how this discussion as evolved. About two years ago we began to consider various incentives Medicare could use to speed the pace of quality improvement. We evaluated a host of private and public sector efforts to incentivize quality improvement, including nonfinancial incentives. The

Commission concluded at that time that Medicare must lead efforts to improve quality through the use of financial incentives.

This was based on several points. First, that the current Medicare payment system is neutral, that is a high quality provider is paid the same as one who delivers low-quality care, and sometimes even negative towards quality. For example, a hospital that improves quality by reducing complications may, in fact, lose revenue.

In addition, Medicare is the largest single purchaser and private sector purchasers told us that their efforts would be much more effective if Medicare were to lead the way.

In addition, you have also expressed concern about the cost of patients of not moving forward in terms of unnecessary mortality, morbidity and the missed opportunities that abound in our current system.

At that the same time, we developed criteria for determining which settings were ready to tie a portion of payment to quality. I'm not going to go through these because we've talked about them on numerous occasions but these are the criteria we've applied in looking at

hospitals, physicians and home health agencies this fall.

Last year, using these criteria, the Commission determined in March of 2004 that facilities and physicians who treat dialysis patients and Medicare Advantage plans met the criteria and at that time we recommended that Congress establish a quality incentive program in those settings.

At that time, you also laid out some design principles for the program. First, that the program should reward both attainment of a certain thresholds and to encourage the broadest amount of improvement possible to also reward providers that improved over time. In addition, that the program should start by withholding a small percentage, 1 to 2 percent, of total payment and then redistributing it on the basis of quality but that that percent might actually increase over time as a broader set of measures was developed and the measures were improved.

In addition, those dollars should all be distributed so there would be none held back for the Medicare program. And that over time, measures must evolve so that, in fact, if we reach high levels of performance on some measures we may need to move on to new and better measures.

To evaluate measures for hospitals and physicians, we talked to an inventoried measure sets from CMS, accreditors, the National Quality Forum, purchasers and plans, various hospital organizations, as well as physician organizations, researchers and also state initiatives. For hospitals, we found that a wide variety of measures of clinically appropriate care are common across measure sets but, in fact, found that 10 were found in almost every measure set.

These were the initial starter set that was used in the voluntary reporting initiative, which is a public/private partnership of hospital organizations, CMS, JCAHO and others. And then the MMA required hospitals to report on these measures to receive a full update.

As a result of this emphasis, as of last week 4,000 hospital scores have been reported on the CMS web site, including scores for 200 critical access hospitals, which is interesting because they actually were not subject to the MMA incentive.

In addition, the voluntary reporting initiative has another set of measures that they intend on rolling out in the next six months to a year, which would give us a

wider variety of measures to look at hospitals on, including such crosscutting measures as surgical infection prevention.

We also looked at outcomes measures and also found a wide variety of outcomes measures are used, in particular to look at mortality and complication rates. However, in talking to experts in the area, we found strong consensus only around a few in terms of whether they would be useful for pay for performance but there was a lot of discussion about the ways to actually improve claims information to get better information on outcomes and, in particular, the suggestion was that if we could flag whether secondary diagnoses were present on admission it would be very useful in improving risk adjustment for mortality scores and to help discern complications that were present on admission from complications that may have been the result of hospital care.

The next two sets up there are crosscutting measures, crosscutting in the sense that they apply to all types of conditions as well as all types of hospitals, both small and large, including some rural hospitals. These are useful parts of any measure set because we have some limitations in the sense that hospital do have different

emphasis on different conditions. So if you were measuring the quality of heart care, for example, it might not apply as broadly as if you included crosscutting measures in your set.

There's a survey that has been developed by the Leapfrog Group to measure hospital safe practices. This is based on a set of practices that were identified by the National Quality Forum and endorsed by then, including such practices as hand washing practices and strategies for preventing infections in hospitals. This survey has already been filled out on over 1000 hospitals.

In addition to this tool, a standardized tool for measuring patient experience of care, hospital CAHPS, has been researched for years and is expected to be issued in final form later this year.

Our experts also told us they felt like accreditation was a good measure of a hospital's basic ability to improve quality.

In summary, the analysis shows that measures of clinically appropriate care are well accepted and that a subset are already collected by CMS, that a few outcomes measures are also available and by improving claims the set

could be much broader, and that measure sets and tools to collect data are already used or almost ready to be used to evaluate hospital practices to prevent errors and patient experience of care.

Therefore, this draft recommendation reflects the conclusion that it is feasible to link a portion of hospital payment to quality and the draft recommendation reads: the Congress should establish a quality incentive payment policy for hospitals and Medicare.

We see that there would be no impact on spending, that it would improve the quality of care, and some providers could receive higher or lower payments, depending upon their quality performance.

We recognize that some hospitals would experience additional burden of all these sets were used. But we also acknowledge that these efforts might encourage increased alignment of quality improvement measurement efforts across external organizations. Thus, this could minimize hospital burden in the long run.

The second recommendation is aimed at significantly expanding the set of outcomes which can be derived from claims. I already describe why this would be

useful. Knowing whether any of the secondary diagnoses were present on admission would improve risk adjustment and could help us discern which complications may be the result of hospital care. Coding and quality experts have been discussing this possibly for some time and recently the National Committee on Vital and Health Statistics has supported this recommendation. The Agency for Health Care Research and Quality has supported this recommendation. The Consumer Purchaser Disclosure Project has supported it. And the National Uniform Billing Committee, which develops and maintains the billing forms for hospital over time, has included a field where hospitals can flag this in the UB04.

The implication on spending is that there would be no impact and we see no impact on beneficiaries or providers. However, we do acknowledge there may be some increased activity for hospitals but it does not appear this would be any significant increase in the amount of work that coders would need to perform.

Physicians guide much of the care beneficiaries receive. Without their participation in pay for performance initiative, any pay for performance initiative will be less effective. Further, use of information technology to

manage patient care and assess performance is expected to improve quality and can be measured. Therefore, measures aimed at that goal should be a central part of the program. However, the Commission has told us that you feel strongly that not just the acquisition of information technology should be rewarded, but the actual use of information technology for functions that improve quality should be rewarded.

So measures in this set, for example, could include whether a physician had a patient registry and used that patient registry to identify diabetes and then also sent follow-up reminders. In addition, this could be used in the area of specialty care to track whether patients received the appropriate follow-up care and to make sure that the referring physician actually received the information on the specialist assessment. These measures could be met by physicians with information technology or without information technology. But because it would be easier of a physician used information technology, we believe this will be an incentive for physicians to acquire information technology.

This measure is crosscutting in the same way I

spoke about in the hospital world, in the sense that it cuts across different types of conditions as well as different types of physicians, so it can be used to measure quality in all physician care.

In addition to those types of measures, we found that there were a wide variety of clinically appropriate care measures but the question there was whether we would want to require physicians to give additional information through medical record abstraction or flow sheets, or whether we should rely on the information that can be gathered through claims.

The Commission felt that to the extent possible we should rely on currently collect information. However, it was uncomfortable with just leaving the claims based information at its current level, and there are a couple of recommendations that the Commission talked about to improve the data, and that would be able to be able to use lab values as well as prescription data to measure the care of physicians.

In addition, a patient experience survey is under development at AHRQ and could be used in the future when it's out in final form.

In summary, encouraging physicians to use information technology to better manage and assess patient care is of great importance to Medicare, and it is possible to measure physician progress in doing so. some claims based measures of clinically appropriate care are available and could be greatly improved with lab values and prescription data, and eventually a standardized tool for measuring patient experience of care will also be available.

Therefore, we conclude it is feasible to tie a portion of physician payment to quality and draft recommendation three reads that Congress should establish a quality incentive payment policy for physicians in Medicare.

We see no impact on spending. It would improve the quality of care. Some providers could receive higher or lower payments, depending upon their quality performance.

Again, we acknowledge some increased burden on physicians for filling out a survey on their care management practices that could be performed by using information technology. However, no medical record abstraction or flow sheets would be required. Therefore, we believe the increased burden of data collection will be minimal.

Draft recommendation four is aimed at improving

and expanding the information on patients by including information Medicare can analyze on lab values. For example, without lab values if a test is performed we simply know if the test was performed. We don't know if, in fact, the patient's levels were in normal ranges or not. It's not without precedent that clinical information is included on claims. For example, dialysis facilities already report two types of lab results on their claims.

Therefore, draft recommendation four reads: CMS should require those who perform lab tests to submit lab values on claims or separately using common vocabulary and messaging standards. Chantal will speak in more detail this afternoon about the utility of using common standards.

We see no impact on spending and the implication for beneficiaries and providers would also be none. Again, however, we would acknowledge there would be some increased burden on those who perform labs and that would include some hospitals and physicians but we believe, again, that this would be a minimal burden.

Draft recommendation five is also directed at greatly improving the data by making it possible for Medicare to actually use prescription data to look at

physician care. This type of data helps Medicare identify patients who have certain conditions and whether they are receiving appropriate care including whether they actually filled the prescriptions they received. Those who use claims-based measures say these data would greatly enhance the utility of the data sets, the data that we can get from claims.

The recommendation reads: CMS should ensure that the prescription claims data from the Part D program be available in enough detail to assess the quality of physician care.

The spending implication would be none and the beneficiary and provider implication would also be minimal.

Now Sharon's going to go through the summary and recommendations on home health care.

MS. CHENG: The third sector we'll discuss this morning is home health care. Because of the relatively weak definition of this benefit, the lack of many clinical standards and the wide variation that we've observed in the services delivered in this benefit, pay for performance could have been especially important role in this sector in aligning what Medicare buys with what Medicare wants to

purchase. Rather than paying for visits or episodes, pay for performance in home health would allow Medicare to attach some of its dollars directly to purchasing better outcomes for patients who are cared for under this benefit.

When we discussed the available measures with the Commission back in September, we heard support for the functional improvement and stabilization measures and the clinical improvement measures that are based on the OASIS patient care tool. These measures are widely used and already collected by CMS. Risk adjustment is necessary for this set of outcome measures and is adequate for a core set of these measures. Including the prognosis and the length of stay in the risk adjustment are ways to avoid penalizing agencies who care for many longer stay patients whose goals may differ from the shorter stay patients.

Adverse event measures, such as rehospitalization or the use of emergency room care, could also be useful measures of the quality of care in this sector. However, more research is needed. We also heard a desire to encourage the development of process measures and patient experience measures for this setting. These measures would enhance the starter set that we're proposing to more fully

capture the range of patient's goals from achieving functional outcomes to achieving independence at home to staying safely at home.

Based on the analysis that we've done and the input that we received from you in September, we conclude that it is feasible to link payments to quality in home health.

Draft recommendation six reads: the Congress should establish a quality incentive payment policy for home health agencies in Medicare.

The spending implication of this would be to have no impact. The beneficiary and provider implication would be the improvement of the quality of care and some providers could receive higher or lower payments depending on the quality of their care.

We acknowledge, too, in this setting that OASIS assessment of every patient at the beginning of care and their discharge currently requires substantial time and effort. However, since it is currently collected and is a current condition of participation, using these OASIS-derived measures to formulate these quality measures would pose only a minimal new burden.

We also bring draft recommendation seven because patient safety is an important aspect of home health care quality, and we'd like to be able to improve our measurement of it. One of the primary goals of home health is to ensure that the patient is able to remain safely at home. And while there are good reasons why a home health provider might send a patient to the hospital or to use the ED, it is also important be able to measure when these hospitalizations or ER use are linked to poor quality care.

Therefore, draft recommendation seven reads: the Secretary should develop a valid set of measures of home health adverse events and include adequate risk adjustment. The spending implication is this would have no impact and the beneficiary and provider implication of developing this measure would be none.

With that, we wrap up our presentation and open it up for your input.

MR. HACKBARTH: Could I start by just addressing a couple issues I think we've discussed before? They are the size of the pool and what it means to say that the measures are well accepted. Let me start with the latter first.

At our last discussion, Arnie asked the question

well accepted by whom, basically. And I think the agreement was it's well accepted by basically expert opinion, people who have clinical expertise, measurement expertise and can provide some assurance that the measures are valid, reliable and so on, as opposed to just generally accepted by the provider community. I think that's the message that we agreed on there and I just wanted to confirm that that's what we're talking about.

Then with regard to the size of the pool, I think where we are -- and please feel free to disagree -- is we've talked about a small amount, 1 to 2 percent, as the starting point and leaving open the possibility if not desirability of that percentage growing over time as we become more confident in the tools, develop broader measures of quality and the like.

I see a lot of people nodding and I just want to make sure that's that message that we're conveying.

Other questions or comments for Sharon and Karen?

DR. NELSON: I take it that you're inviting comments on all of the recommendations?

MR. HACKBARTH: Yes, I think that's the best way to do it.

DR. NELSON: First, I'll state the obvious, that the impact, a possible worrisome impact on access, would be lessened if there weren't losers who couldn't provide the data or who appeared not to have high quality for whatever reason and yet still may have a fairly large Medicare load.

So if it were possible to bring in new money so that high performance could be rewarded without penalizing those whose performance doesn't measure as well, the worries about access to care would be lessened. And certainly that is something that I would advocate.

With respect to an issue that's not quite as obvious, having to do with submitting the results of lab tests, I'd be more comfortable if we called for demonstrations to assess better the feasibility of that, not so much because of the ability of large commercial labs to provide those data, but an awful lot of Medicare laboratory tests are done in physician's offices. It's one thing to be able to record that a lab test was ordered or done and submit that as a bill. It's quite another matter to collect the results of that, those laboratory tests, downstream.

Some of the lab tests may require a period of time, such as cultures and things of that sort. The

practical impediments to collect those data and submit the results may be much greater than we are recognizing.

So rather than jump right into that at this point, I think it would be healthy for us to have more information about the impact with respect to the administrative burden.

MR. HACKBARTH: Any response on that issue, Karen?

MS. MILGATE: Just that in talking to people that are more familiar with how lab results are done, we did hear the comment that they did think it would be much easier for the large labs to do this. One of the pieces is not just to record the value and report the value, but also to standardize the messaging standards. That was another piece that they said the larger labs would more easily do. So it might be something we would need to look at in more detail on how easy or hard it would be for physician offices.

MR. HACKBARTH: We'll take a further look at that and consider how to address it.

DR. CROSSON: Thank you. This is the beginning of, I think, a very good direction. And I think it's a little bit historic on some level, even for a newcomer it feels that way to me. I'd like to compliment Karen and the rest of the staff for the work that's been done here.

I'd like to address one specific comment to recommendation three, which is the recommendation for payment policy for physicians. There is a strong relationship between the whole pay for performance idea and the use of clinical information technology. They are linked. They have been linked in the discussions we've had and in the analyses. If you go back and forth between the two papers that we are going to review today, they are there.

My own sense is that they are justly linked because in the end, in order to really get depth, consistency and reproducibility of information, clinical information, that's broad enough to involve enough physicians and enough care and enough patients, you're going to have to have the information flowing from clinical information systems.

Of course, the barrier is simply in many cases that the business case isn't there, at least for some.

My sense has always been that if there is clarity that over time payment is going to be linked to information which can only flow from clinical information systems. Then that becomes a factor in building the business cases at all

levels.

So my concrete suggestion is that we consider adding to draft recommendation three a specific reference that could read something like this: over time such a policy should be designed to encourage the diffusion and use of electronic medical records.

MR. HACKBARTH: Let us think about that. The obvious other path is to make the sort of statements that are in the draft papers in this chapter in the accompanying text. And all other things being equal, I sort of prefer to keep the recommendations simple and embellish with the language in the text. But we'll think about how to address that.

MR. SMITH: Thank you. Glenn. And Sharon and Karen, thank you very much. This not only was a useful paper today but the last several months worth of work and the way that it's built have been particularly helpful. I think we are all appreciative.

Let me pick up on Jay's comment for a bit. I was going to wait and talk about it when we talked about the IT thing. But I do think we should consider sending a signal or maybe even being even stronger in arguing that by a date

certain these capacities need to be in place and systems need to be in place which effectuate that. That should be a condition of participation. I think we ought to hint at that, even if we don't go so far as to say it. But I do think the place to say it more directly is the IT chapter.

But back, Glenn, to where you began, the size question is an interesting one. Arnie and Ralph talked about it at some length, I think, at the October meeting. We've all talked about it a little bit. We've got two interconnected questions. One of them is how much is enough to be potent? And we don't know the answer to that. My suspicion, but it's an uninformed suspicion, is that 1 or 2 percent probably isn't very potent. And how to get a handle on how much is potent, it seems to me that it's time to involve some game theorists in helping us try to get a handle on this. And that as we get more sophisticated in thinking about this, we need more sophisticated information than we have. And I'd like to see if we could pursue the literature and maybe engage some consultants that could help us.

The other question, Alan, is how much is enough to be potent? And then how much is too much, so that it drives

people out? We don't know the answer to that, either. But it does seem to me that as we proceed down the pay for quality road that we ought to be prepared to drive some people out. Again, we need to get more of a few than we can get from our best guesses and intuition about at what level of requirement and obligation and standard would we begin to lose people? Or to what extent would the obverse happen, which is a general upward leveling of performance which is what we all assume, to some extent, we get out of this.

I'd like to be tougher about robustness but we need to do that, or at least I need to do that being very modest about how much I understand about the answer to how much is enough. But my guess, Glenn, is 1 to 2 percent isn't enough.

DR. REISCHAUER: Just on how much is enough, these payments are going to be focused on a minority of providers. So if they want to say a third of the providers, you're talking about it being 3 to 6 percent. And I think the notion is that, as we said, over time the amount would grow. The total size of the pool would grow. And as we became increasingly comfortable with our measures and they were ferreting out the kind of quality that was important, you

could see this growing much more.

So I think this is not a feeling -- this is more signaling in the first year or so about a more profound change that is going to evolve over a five or 10-year period.

MR. HACKBARTH: The one point that I would add to that, I agree with all of that, is that to be practical about this at the outset there is also an interaction between update factors, the amount providers are paid, and the size of this pool. In trying to start a new program and move in a new direction, I think that's a constraint not just for us but more importantly for the Congress that they've got to deal with.

So if you're talking about a big spread initially, bigger than 1 to 2 percent produces, you are potentially bumping up against real economic and political constraints.

MR. SMITH: If I could, I agree with both what you and Bob said. I don't think, Glenn, with all due respect to you and all of my other colleagues, I just don't think we know enough.

And Bob, the pool could be quite large if we're looking to reward improvement, which we want to do as much

as we want to be reward attainment. The larger the pool gets the last kick there is from the distribution of a relatively small number. We just need some help in figuring that out.

MR. HACKBARTH: And we need to move on. I just want to be clear that I agree with your point about how much I know and I feel like it's this big. [Indicating.]

I think we're going to be spending a lot of time in this field and we'll have ample opportunity to learn more and consult with different experts and the like.

Dave Durenberger, was your point on this particular issue?

MR. DURENBERGER: I can wait.

MR. HACKBARTH: Next in the line then is Mary.

DR. WAKEFIELD: My comment relates to draft recommendation one and it's a real targeted comment.

First, let me just say I support the recommendation. the comment I have is related to the text associated with it.

Karen, you mentioned that the 10 measures that are being reported to CMS already and good participation actually by CAHs, who are not obliged, and I think that's

laudable obviously.

Here's my question for you. Do you have a sense of the extent to which either the CAHs or the small rural PPS hospitals are able to report or are reporting across all of the cells available? So in other words, are they having sufficient cases in most of the cells to be able to put something here? Or are they having to asterisk?

I'll tell you why I'm asking you that question, because as we move in this direction I want to make sure that if there needs to be a cautionary note there is in the text, that talks about whether or not with low case counts low and how do those hospitals reflect improvement if the data are insufficient, if there aren't enough of the cells basically that are filled?

So if you don't move the mercury in the thermometer far enough because the N is too small in a number of cells then that's an issue and I think that cautionary note ought to be expressed.

On the other hand, our experience to date might suggest it's not an issue. So can you answer that question?

MS. MILGATE: I can't answer it fully but I can give you some of what we know on it. The data to look at

that specifically is now available on the CMS web site and we haven't looked at it in great enough detail to know what percentage of hospitals of X size, for example, could do all of the conditions or not.

However, just to say one thing, we did look at what's on the CMS web site and look at one particular large hospitals in the area and found that even they had some difficulties in terms of cells sizes for some of the conditions you would think that would be broad. So I think it is an issue. They've chosen some broad measures. As I recall in a general analysis we did, we found on the pneumonia measures they were more broadly applicable than the heart ones, for example.

So I think we'll just need to look down the line. But we didn't find hospitals that couldn't report on some of them. Everyone could report on some of them. But I do think it's an issue that we need to look at and that's one reason we emphasize crosscutting measures for the hospitals, as well.

DR. WAKEFIELD: If I could just add that depending on what else you learn between now and January, if there is a need -- in terms of structuring a quality incentive

payment policy, if there's a need that we could reflect in text to accommodate this small sized problem, then I would appreciate it if that point would be made. I've raised this issue, I think in the last meeting as well as the meeting before.

MS. MILGATE: That's a very good point and it also raises another issue about how you might design it so that you might emphasize in your index, for example, the crosscutting measures versus the condition-specific measures if, in fact, you had some concern about the simple size in the beginning when you started just looking at some smaller set of condition-specific measures. When you start expanding it then, of course, it's less of an issue. And that could be reflected easily in the text, yes.

DR. BERTKO: First of all, too comments. One to be complementary to your report again and just say that the large employer community certainly is supportive of this, demanding of it in fact. And to the extent that Medicare can take one of the leading roles in this, it makes it easier all around to get this done.

The second comment is more specific to draft recommendation five on collecting prescription drug data. I

think that this one ought to stand strongly because CMS and the Office of the Actuary, from what I understand, will need this same type of data to do both the threshold updates on an annual basis and then more specifically on individual level people who do reinsurance calculations in a very quick basis. So having us ask for a modest additional stream of data that's collected all at the same time seems quite reasonable and a good synergy.

MR. MULLER: Let me also echo some of the comments that John and specifically David made and also point out specifically with regard to whether, for example, electronic records should be a condition of participation and also the size of the pool.

I would also point out that while oftentimes our considerations do and our agendas and chapters overlap, they seem to be more specifically overlapping today in a way that's a little puzzling to me. For example, how I would think and vote on the recommendation on these quality pools is very much affected by what we do a little later on how we think about the update. And as David pointed out, how we think about electronic record is very much also how we look at the chapter on information technology.

So I'm just expressing this concern out loud, as we vote on these, as we come back later today and tomorrow and then in January, there's an interrelationship in how I think about these as stand alone items. For example, I'm in favor of over a reasonably speedy period of moving towards electronic record as a condition of participation, with some outs for those places that really can't comply. But I would think a large proportion of the country could comply. But I also then think the quality pool is affected by the update recommendation.

So I wanted to keep that in mind as we go through these considerations over the balance of the morning because we do have quite a bit of overlap in the policy issues here.

MR. HACKBARTH: I understand your concern about that and let us think about how to manage the process for January and make clear that the interactions are there and address them appropriately.

DR. WOLTER: On the potency issue, I would just say that -- and I don't know whether we're talking about a percentage of the update or a percentage of the standardized amount yet. And I don't know whether we're going to address that, so that's one of my questions really, is will that be

part of our final recommendation?

But for our organization, which is really quite small, we have about $61 million in Medicare net revenue. And 2 percent of that would be a huge incentive to us to have that at risk for quality. I think the track record of the 0.4 percent does tell us a little bit of something about the response that it got from the industry. So I wouldn't really characterize this as a small incentive myself. Of course, I live in that world.

I am very supportive of these recommendations. I agree with Jay. I think this is the beginning of something that will pay big dividends over time.

I do have a number of questions. The current measures are quite narrow. There's a heavy focus on cardiac. I know you've done a nice job, Karen, describing expanded measures which are out there which can be used.

The question I have is how do those get put in place? Where will the decisionmaking reside about looking at the expansion of measures? The process of that and where the expertise resides to put the right measures in place is really a critical issue. So I don't know whether we should be having any discussion about that, whether that's AHRQ or

IOM or a public/private group. But I think that's really important.

Already one of the current 10 measures is under a reasonable amount of question as really being the right evidence-based measure anymore. And similarly, amongst physicians we have so much specialization that in the initial wave of this it's very likely that some will have more opportunity than others, depending on which measures are chosen. And that's going to present a dilemma in terms of administration of this. I think that will be important.

If we were to look at the percentage of an update as the mechanism for this, currently the hospital update is geographically adjusted. So one question I'd raise there is if we have a fixed portion of the update available based on quality but we geographically adjust the whole update, some organizations will find themselves with a percentage of that update more at risk than others. So some details like that, I think, are very important to deal with.

I'm also concerned, as is Mary, about the fact that there are going to be many hospitals who do not provide the services that may be in the initial wave of measures. That would be similarly true for physicians. We just need

to make sure that doesn't automatically create a penalty in terms of how the opportunity gets set up.

So those are really more process than detail questions.

MR. HACKBARTH: Let me address a couple of them quickly and then some others we may need to discuss offline and come back in January with the conclusions.

With regard to how the pool was created. The framework that we've talked about is that it's out of the standardized amount, as opposed out of the update. Mathematically, in terms of the dollars, it works out the same way. But from my perspective, we said the standardized amount so that you could move forward with quality pay for performance even if there were a small update or no update in any given year. We're trying to establish principles here to endure over a period of time so I'm not sure that we want to tie it to something as variable as the update. That's my perspective on it.

The second question about who decides what measures are ready to go, I think is a very important one. I don't think it ought to be MedPAC. I don't think that that is our distinctive competence, if you will. But I

think it's a critical question for the process and it links to my earlier observation about what we want our well accepted measures by credible experts.

And what I would hope is that over time what evolves is an institution or a couple of institutions that are renowned for being that kind of expert. Maybe NQF over time, I don't know. The people who have both access to the clinical expertise and the analytic expertise to say that these are clinically appropriate and analytically reliable valid measures.

So what I want to do is have that sort of statement in the text, that this is how we see it evolving. In any given year the final decision may not be delegated to the private entity and will be made by the Secretary. But I think it definitely has to be informed by credible expert opinion. And that I felt very strongly about. This will come to a crashing halt if that test is not met.

DR. WOLTER: So it might be important for us to be very clear in the text.

MR. HACKBARTH: Yes.

DR. SCANLON: I think this is an incredibly important step and deals with the most glaring flaw in the

Medicare payment policy, which is to pay everybody the same regardless of quality. I think that the principles you've outlined, I can feel very comfortable with all of them.

But at the same time, the structure sets up for me almost an implicit additional principle which is that we should be targeting these payments on a group of providers that are doing something that's relatively homogeneous. I think that's what you did last year in dealing with the ESRD providers and the managed-care agencies.

I don't think that it's necessarily the case that we've got here. Physicians are a very heterogeneous group. Home health agencies are heterogeneous. And as Nick just said, hospitals differ. I think if we don't provide an opportunity for the individuals within each of these groups to have the same probability of succeeding that we've created an equitable and potentially an intolerable situation.

When I went through the measures that we've reviewed over the last few months, it's very clear that it's uneven in terms of what it's going to be -- think about physicians especially -- what different specialties are going to do or what's going to be asked of them.

it's one thing to say we need IT, and I agree with that completely. But then we say we don't want them just to have a computer in their office, we want them to utilize it. But the standards for what utilization is are going to differ by specialty. It's going to be one thing if you're a primary care physician and we're asking you did you deal with your patients through your IT system? Versus say a pathologist whose responsibility it would be to get a lab report to the referring physician. Very, very different kind of situation.

I'm concerned that we're not at the point that we should be ready to be passing this off to someone else to figure out all of the details. I'm thinking that we should have spent more time on this to develop more structure here that we can put into -- if you want to keep the recommendations about -- into the text behind the recommendation so that someone has a clear sense of how they can proceed.

At this point, if I were to be given the assignment of drafting the legislation, I'd be at somewhat of a loss. And I might be in the situation of kicking it to the next step, saying the Secretary shall figure this out.

And I'm not sure that's the best approach to this.

MS. BURKE: Let me begin, as Bill did, and suggest that I, too, support the recommendations and think we are headed in exactly the right direction. I also want to underscore Bill's concern about how quickly we can move across all of these venues given what we have available to us in terms of measures. I think to make it successful, the opportunity to be successful will be critical. So I want to underscore exactly the points that Bill made. I have the same anxieties about how ready we are to go on all fronts across the board.

Let me also raise just a couple of other specific questions or concerns. One, not only do we need to be concerned about the relationship in terms of the update and the funds that would be available to the extent we set up any pool in the broader context. I also think we cannot underestimate the impact that these changes will have. While the recommendations often say there's little in the way of impact in terms of spending or beneficiary and provider, I think particularly to the point that Alan raised about the issues for individual physicians as compared to the physicians in large groups, a number at the these things

could, in fact, have a measurable impact on the cost of doing business. I think we do want to encourage them to begin to move towards the use of IT. And I think we'll talk about that in the course of our conversations today. But I think we ought not underestimate what the impact might be on an individual physician or a physician in a very small group as to the things that will be necessary in order to fully participate.

Of particular note is the recommendation with respect to lab claims. Again, as Alan suggested, I am less concerned, as you pointed out, that this is an issue for large labs and their capacity and already their existing resources that allow them to report on claims data and essentially transfer that information.

I am concerned about the number of cases where, in fact, those services are provided by physicians offices and their ability to do this and what it will mean in terms of delays in terms of claims or the reconciling of the claims in terms of that information.

So I think that further information for us in anticipation of our discussion in January as to how quickly one might imagine doing this, as compared to large lab

practices and large group practices, and how quickly we might imagine that an individual physician's office could participate successfully and be measured.

And then ultimately I have a question as to what we would envision occurring with respect to our capacity to look at the lab results and the treatment interventions and what eventually occurred. I mean, it is clearly critical to our understanding of the quality of the physician practice, but I wonder about how quickly we're actually going to be able to do that, in terms of individual physicians. So that would also be something I would be interested in understanding more fully when we meet in January.

And then finally, I did have a specific question on recommendation two. There is a reference in the text of the report to the activities going on in two states with respect to the recording of a secondary diagnosis on admission. I wondered, there are going to be issues about the ability to correctly code and to what extent there are errors and to what extent -- I mean, there's no penalty that's referenced here in terms of failure to treat and things of that nature.

But I wonder what the experience has been in those

two states? And have they, in fact, seen successfully the ability to identify it and begin to track it?

MS. MILGATE: Just on that specific question, what I've heard from those -- the way it would work is that coders are in the history and physicals to identify diagnoses already. So it would be simply recording whether, in fact, one of those secondary diagnoses were present on admission or not. so that's sort of the crux of how it would happen.

What we've heard from those two states is when they first put these requirements in place there was a lot of training to make sure that coders did this correctly. And what quality experts have told us is that over time, as some of those originally trained coders have moved on and others have replaced them the training hasn't been as rigorous. And so some of the effectiveness of that coding has gone down over time.

And they were very excited about the concept of actually having it required on a national level because they felt like, in fact, that would mean that it would be taken very seriously as a part of the coding training that coders get. So training is obviously a real key piece of making

this is done correctly.

MR. DURENBERGER: My comments are much like the last three comments on the other side of the table and they go to clarity and what do we mean by quality or pay for performance? I think we've already demonstrated that if we put a penalty up for not reporting process information everybody will comply. We've already demonstrated in the Premier demonstration that if you say 2 percent for some more process reporting, you're going to get 2 percent for more process.

So the principles that I would like to see articulated here around a policy ought to be first, it expedites the process of achieving the goal. Secondly, that it's lasting change, not something every 10 years you're going to start all over again with one of these MedPAC commissions. And third, it ought to be done in the least costly way possible because in the end these costs are being picked up by premium payers and people.

For those of you that took the time to read Atua Gwandi's [ph] piece that was sent to us, it tells this story with regard to cystic fibrosis. The important part of that story is not that Cincinnati was way behind. The important

part of this story is that there are places in America that are already at the excellence we would all like them to be at. And it's those people that need to get the signal as soon as possible that they ought to keep doing the same thing so that others will follow them. That's what I mean by expeditious.

In regard to lasting, I suggest that we look not just at individual doctors but we look at systems of care. Because just changing a few doctors' behavior doesn't do it unless you change the system within which these doctors operate. I'm not saying you have to go to Permanente or something like that. We've talked before about how to look at that. But I think we'd get a lot more out of the lasting side of this if we suggested to the Congress that whatever policy they develop, they begin to focus on systems of care rather than trying to apply this to individual docs all over the country and then run the risk of 10 years from now you finally break down the last national association of barrier.

The last thing that I would love to see and hear on the subject of principles is, and in all of this work, is reference to the IOM six aims. If we talk about performance we ought to constantly be talking about it the way in which

people out there are already talking about it, in hospitals and other places. And that is in terms of those six aims. We've ought to suggest to the Congress and to legislatures and others making health policy that they measure everything that they do by those six aims. And then everybody in the system, public/private, small/large, system/non-system, will begin to understand that this will be in a permanent change in the way we pay for health care.

MS. RAPHAEL: I will echo what everyone else has said. I think the most important thing is Medicare must lead and can really influence what happens throughout the nation in many other areas.

There are two points I wanted to make. One is I am a proponent of starting with the 1 to 2 percent pool because I think right now the measures are narrow. For many organizations 1 to 2 percent is significant, or whatever it amounts to in payouts.

In addition to which, in general people in this field want to succeed. We're competitive. We've learned from Nursing Home Compare and Home Health Compare that even if there isn't great differentiation it has the greatest impact on provider behavior. And we respond with great

sensitivity to that. And also, because I think it takes time to build the infrastructure to respond to these.

Secondly, one of the things that I feel we need to pay more attention to -- and maybe it's kind of building on what Nick was saying -- is I didn't see and hear a road map for how we think this should evolve over the long term. There's a lot of focus on measures. And measures are one ingredient in a successful kind of value purchasing strategy.

But I really think we need to think through how are we going to get to consistent domains because we ultimately want to be able to measure quality in a longitudinal way. And we want to try to have more integration even in a fee-for-service system. And in order to do that, we do need to figure out where are each of these sectors in regard to outcomes, process, patient experience, structural measures, et cetera? And how are we going to get further along the road? And where is the capacity going to come from to do that?

I don't think that we've yet given thought to that. We spoke briefly about who should be the ones to do the measures and update them, and that's certainly something

we need to think about. But for me, to make this successful there has to be some capacity. Is it in CMS that that capacity needs to be built to really, over the long term, execute this? I would just like to give a little more thought in the text to that whole set of issues.

MR. HACKBARTH: A piece of that capacity that I've long been concerned about, dating back to my time at HCFA, is the research foundation which ultimately leads to evidence-based standards of care. I have long felt we way underestimate in the development of the knowledge base that can then guide these things in the future.

We will try to lay out the road map or present a clearer sense of direction for this. I think that's a helpful comment.

Arnie and Pete and Bob, and then we really need to move on.

DR. MILSTEIN: The IOM has repeatedly given us advice in sequential reports over the last 10 years on this topic. They keep saying it needs to be our goal and every other program payers goal to achieve not just an incremental boost but a massive boost in providers prioritization of performance management, both quality and efficiency. I

personally thing this chapter is an excellent step in that direction. I think it's terrific.

A few specific comments, not very many of them, related to further refinement of the chapter, and most I think I realized intended to respond to some prior comments by some of my fellow commissioners.

On potency it's a tough call. I would, if anything, favor stronger language that indicated no increase in what we recommend in the near-term but maybe more explicit about what we think the buildup -- the buildup ought to be continuous until such time as we see such a northward movement in performance that we say enough. Because I think game theory will help us but I think this is an area, as I read the literature, where we don't really don't have good information on what incentives it takes to get us how much further up. So I support the current potency and I would love to see us also indicate that over time we'd like to see it increased until we get where we need to go.

On the hospital measures, it's the one area of the report I want to just suggest look, the NQF has endorsed 30 safety practices. We've had a series of respected reports

in the last month saying we're now six years post To Err Is Human and the estimated deaths. We have 30 hospital safe practices. We have a method of reporting on where hospitals stand in relation to those practices. Already 1000 American hospitals are finding adequate for reporting. I love to see us explicitly tie our recommendation to where hospitals stand on the 30 safe practices.

With respect to NQF, I agree with the earlier comment. Here's a multi-stakeholder body that's in the business of endorsing performance measures. I personally would support deferring to them explicitly, but I'm also happy to leave the chapter as is.

On lab test results, with respect to Alan, it's a serious business. It pertains not just to the Medicare program but to terrorism control. If you want to do lab tests, it's become a serious part of American day-to-day activity. I just think you have to step up and be there.

So while I certainly agree we have to be mindful of unintended consequences, I personally think that the time is long past for ending what has been our implicit culture of low expectations of both performance and performance reporting of the health care industry. I don't think

there's anyone in this room who is today willing to accept random assignment, if they were very ill, to any Medicare participating doctor or hospital. And I think it needs to be our goal that in a short amount of time we would be comfortable with random assignment if we were seriously ill because that's the predicament that Medicare beneficiaries are in today.

MR. DeBUSK: For the sake of time I will yield my turn to Bob.

MR. HACKBARTH: Are you going to agree with me or you going to say something contrary?

DR. REISCHAUER: I'm going to say that I think the issue that Bill raises is a very fundamental one which we have sort of skated over completely. That we're all for pay for performance and as an exhortation that's great. But are we sending the Secretary down the road for which there are no bridges at every river across crossing?

What Bill is saying is the system we can think of for physicians may be totally inappropriate for certain subcategories. And the issue which I think we should raise in the text is whether we think this should go forward with a broad brush, even though some of it would, in a sense, be

irrational really for certain subgroups. Or we should say meaningful subcategories of these provider groups could be created by the Secretary and the pay for performance mechanisms directed at them. And as we develop other measures for the other subgroups we apply it there. And I think we should just raise that issue and not duck it.

MR. HACKBARTH: Okay, thank you very much.

The next item on the agenda is assessing payment adequacy for hospitals. Jack?

MR. ASHBY: Good morning. This presentation will address the adequacy of Medicare's payments to hospitals for all of the services they provide to Medicare beneficiaries and payment updates for inpatient and outpatient services in 2006. We have quite a bit of material on margins and cost growth but before we get to those issues we wanted to briefly review the evidence on the other payment factors, other payment adequacy factors, much of which was presented at the October meeting.

We presented evidence that access to care remains strong, as evidenced by a small net increase in the number of hospitals in the program and an increase in the share of hospitals offering a number of specialty services. We found

that volume of services continues to rise and we found that access to capital is generally good, as evidenced by large increases in construction spending, bond issuances and future expansion plans.

Today we have the results of the last of our payment adequacy factors, quality of care, and for that we turn to Tim.

MR. GREENE: We analyzed risk-adjusted mortality indicators developed by the Agency for Health Care Research and Quality. AHRQ chose these indicators based on evidence that their rates were related to the quality of inpatient care. It reports great variation among hospitals in performance on these measures.

We examined changes from 1998 to 2003 in the in-hospital and 30-day mortality rates of beneficiaries hospitalized with eight conditions or procedures. Results are generally consistent with those we reported last year and with change from 2002 to 2003. A negative means a declining mortality rate in this table.

In-hospital mortality improved across the board. 30-day mortality also generally improved. However, death rates increased for patients hospitalized with pneumonia and

stroke. In both cases, rates per 10,000 discharges increased less than 1 percent over the five-year period.

We also examined changes in AHRQ patient safety indicators that identified potentially preventable adverse effects related to hospital care. This slide shows eight of the 13 patient safety indicators we analyzed. The risk-adjusted rate per 10,000 discharges increased for six of the eight indicators we display here from 1998 to 2003. Once again, the results were consistent with what we reported last year and for the 2002-2003 change alone.

Finally, we also examined data from the QIO program on measures of clinically appropriate care for hospitalized patients with specified conditions. I don't have an overhead for this. Care improved for 18 of 25 measures. Despite the improvement, many beneficiaries are still not receiving care known to be effective.

MR. ASHBY: Now, as we move on to our financial information we see two themes for hospital payments in 2006. The hospitals need to have fiscal constraint to restrain their cost growth and that Medicare needs to pay more to higher quality hospitals. But the evidence is mixed this year. The other factors in our update model are generally

positive, as we just heard, but Medicare margins have fallen rather substantially.

Our measure is the overall Medicare margin which includes, along with inpatient and outpatient care, hospital-based home health, SNF, rehab and psych plus GME. As we see in this table, this margin has dropped a little over four percentage points in 2003 to minus 1.9 percent. The inpatient margin has dropped even a little more, almost five points, while the outpatient margin fell 2.5 points.

One of the key reasons for the drop in margins in both 2002 and 2003 was a large increase in unit cost, which we will detail in a moment. But on the inpatient side, there is one other key factor and that is outlier payments. These payments were much larger than intended through 2002. We then had reforms in the system and that has brought the margin down a full percentage point in the first year.

I would also note that the 2003 margin reflects the impact of provisions reducing both hospital-based SNF and hospital-based home health payments.

The next slide shows our unit cost increases. Focusing on the case mix adjusted numbers, inpatient cost per discharge rose 7.4 percent in 2002. That's the largest

increase that we've seen since 1990. The increase then dropped to 5.6 percent but it's still the largest increase that we've had since '92. On the outpatient side we had a smaller increase, 2.5 percent, and that smaller cost increase explains the smaller drop in the outpatient margin.

One of the key reasons for the lower unit cost growth on the outpatient side is that outpatient volume increased very substantially in 2003, more than 10 percent.

We have some evidence, though, that the rate of cost growth may be moderating. Let me clarify first that we are using a different measure here. This measure covers all hospital services for all payers. On the previous page we were talking about a Medicare cost measure. With this all-encompassing measure, we estimate 2003 cost growth at 5.1 percent. Then a survey that we sponsored together with CMS provided the estimates you see here of 3.4 percent, using the same measure, for the 12 months ending in June, 2004.

We also have BLS data that tend to corroborate the reduced rate of growth. BLS reports that the rate of increase for hospital compensation was 0.5 percent lower in the 12 months ending June 2004 compared to the previous 12 months. And along the same lines, the rate of increase in

hospital employment is 0.7 percent down in 2004 over 2003. We have to remember that the compensation rate and employment combine to define labor costs. So these two increases, the 0.5 percent reduction and the 0.7 reduction are roughly additive. They imply a 1.2 percent decline in the rate of increase which is consistent with the CMS/MedPAC survey.

The next slide shows our margin projections. First, a reminder that in projecting to 2005 we include the effects of 2006 policy changes that affect the distribution of payments. So what we're were estimating here is basically what payments would have been in 2005 had 2006 policy been in effect at the time.

As we can see, the overall Medicare margin rises 0.4 from 2003 to 2005. But the inpatient margin rises more due to several MMA provisions which more than offset costs rising faster than updates. The outpatient margin, on the other hand, falls due to a combination of the high-cost growth and two MMA provisions that reduce payments. First, the removal of the transitional corridors at the end of 2003. And second, removal of the hold harmless provision which applies to small rural and sole community hospitals at

the end of 2005.

Next, we look at our margin projection by hospital group. The MMA provisions primarily help rural hospitals. Their margin, as you see, rises by 3 percentage points while the urban margin stays the same.

Many of you will remember, though, that last year at this time we projected that the rural margin would surpass the margin of urban hospitals. But that estimate was for 2004, reflecting 2005 policy, and two policies going into effect in 2006 have changed the picture. First is the outpatient hold harmless provision, as we mentioned a moment ago. that policy only affects rural hospitals. Plus, outpatient services comprise a larger share of costs for rural hospitals which magnifies the effect.

Second is elimination of the 5 percent rural add-on to home health payments. Again, the effect of this provision is magnified by home health services comprising a larger share of rural hospitals' costs.

MR. HACKBARTH: Jack, how big is the effect of those two provisions?

MR. ASHBY: I'm not sure that I have an exact figure on that. We could report on that next time. It's

buried in the modeling program somewhere

Now we move into the results of several analyses of cost growth and we will be exploring the premise that the rate of cost growth is directly linked to the flow of revenue from private payers.

We begin by examining the growth in private payer payments over time. Our measure is the ratio of payments from private payers to the costs of treating privately insured patients. As we see on this graph, the ratio exhibits three distinct periods. It is moving up through 1992, it is moving down through 1999, and then up again through the present.

In the first period, private payer payments increased 2 percent more than costs each year, leading to a 16 percent increase in hospitals' profit on business from the private sector. Most insurers still paid on the basis of charges at that point, and engaged in little negotiation or selected contracting. With this almost complete lack of revenue pressure from private payers, hospitals' Medicare cost per case rose more than 8 percent a year.

Then in the second period, we had almost the converse. Private payer payments increased 2 percent less

than costs, resulting in a 19 percent drop in hospitals' profits on private sector business. HMOs and other payers obviously, at this point, began to negotiate harder and most switched to paying for inpatient services on the basis of DRGs or flat per diems rather than charges. With the now extensive pressure on private payer revenue, the rate of cost growth plummeted to only 0.8 percent per year.

Then, in the continuing third period, private payments are once again rising faster than costs. Private insurers now generally have less leverage than at any time since the early '90s because of provider consolidation and emphasis on products that grant free choice of providers. The freer flow of funds from the private sector, profitability has already risen by 6 percent, has once again resulted in higher Medicare cost growth.

Finally, we wanted to emphasize that during our earlier experience with high cost growth, the late '80s and early '90s, the rate of growth in Medicare cost per discharge exceeded the increase in the market basket by more than 3 percentage points a year. But our predecessor commission, ProPAC, continued to make update recommendations in relation to market basket.

Even putting aside the adjustments that they made at the time to compensate for base rates being too high in the first year of the PPS, their recommendations during this period averaged market basket minus 0.7 percent, including the three years when the Medicare margin had dipped into negative territory. The actual updates, as you see, were even lower, averaging 2.5 percent.

Next, Jeff will continue looking at the relationship of revenue and the rate of cost growth.

DR. STENSLAND: First, I will show that hospitals facing financial pressure tended to have lower rates of cost growth. This suggests that hospitals have a degree of control over their costs. Second, I will show that nonprofit hospitals in competitive markets tend to have below average rates of cost growth. This suggests that competition can restrain cost growth.

In this slide, financial pressure is measured using profit margins on non-Medicare patients. We focus on non-Medicare patients to highlight the impact of private insurer payment rates which can be affected by competition. Our definition of non-Medicare revenue includes payments from privately insured patients, Medicaid and investment

income.

We find that nonprofit hospitals with non-Medicare margins above 5 percent increased their cost at a rate that was 2.3 percentage points above the market basket from 1998 to 2003. In contrast, hospitals under significant financial pressure held their cost growth to 0.9 percentage points above the market basket. In 2002 hospitals that were under financial pressure were able to keep their standardized cost per Medicare discharge down to $4,750, which is below the level of costs incurred by hospitals facing less financial pressure. Our finding that financial pressure has restrained cost growth over the past five years is similar to findings published by Gaskin and Hadley, who find that financial restrained cost growth during the early 1990s.

We also examined cost growth among for-profit hospitals and found similar results.

We measured competition using a Herfendahl Index. In low competition markets the most dominant hospital had a 73 percent market share on average. From 1998 to 2003 a nonprofit hospital in these lower competition markets increased their cost at a rate that was 1.9 percentage points above the market basket.

In contrast, nonprofit hospitals in highly competitive markets grew their costs at a rate that was 1.3 percentage points above the market basket. The difference of 0.6 percentage points is significantly significant.

Interestingly, nonprofit hospitals in lower competition markets did not have higher costs in 2002. This suggests they started from a lower cost point. This is consistent with the literature which suggests that low competition markets tended to have lower costs in the 1980s. But in recent years, low competition markets tended to have higher rates of cost growth.

We also tested the relationship between competition and cost growth at for-profit hospitals. We found that for-profit hospitals in low competition and high competition markets had similar levels of cost growth. It is possible that for-profit hospitals are more focused on reducing costs, even when they do not face significant competition.

To summarize what I've been saying, hospitals under financial pressure were able to achieve below average rates of cost growth. While below average, these hospitals' costs still grew faster than input prices. This suggests

that cost growth was partially, though not completely, under the control of hospitals. Other factors, such as physician practice patterns, could be playing a role.

Nonprofit hospitals in competitive markets started with slightly higher costs per discharge but they had lower cost growth from 1998 through 2003.

I'll turn you back to Jack.

MR. ASHBY: Our next slide reviews our analysis of hospitals with consistently negative Medicare margins which we presented at the last meeting. These hospitals exhibit the characteristics you see here, which add up to the conclusion that they have not controlled their costs as well as the average hospital, and even less so in comparison to hospitals with consistently positive margins.

In addition, these hospitals generally have a poor competitive stance in their market areas, as indicated by higher costs and lower occupancy compared to their neighboring hospitals. In short, the financial performance of negative margin hospitals under Medicare is directly linked to factors over which their managements have considerable influence.

As in virtually all fee-for-service sectors,

hospitals exhibit a wide range of cost growth for inpatient services. We'd like to illustrate the effects this variation can have on the industry-wide margin. Measured over four years to eliminate the effects of short-term fluctuation, the top quartile of cost increases averaged about 11 percent a year while the bottom quartile average about 1 percent. These results are case mix adjusted.

But we found that many of the hospitals with the largest cost growth had the lowest costs in the absolute at the beginning of the analysis. So focusing only on the subset of hospitals with above-average costs going in, if these hospitals had held their cost growth to no more than 2 percentage points above the market basket from 2001 to 2003, then the margin would have been 2.3 percentage points higher.

We did this analysis only on inpatient cost but if the dynamic carries to the other hospital services -- and it's likely that it does given the extent of joint costs -- than the 2.3 percent higher margin would, all else equal, carry through to our projection for 2005. And we would end up with a positive overall Medicare margin rather than the minus 1.5 percent that we estimated for all hospitals.

Turning to our conclusion on payment adequacy, as I said at the outset the evidence is mixed. But hospital mergers and the retreat of private payers have fueled cost increases that the evidence suggests are excessive. And as was the case in the late '80s and early '90, more of the burden for controlling costs now falls on Medicare. Both the need for cost constraint and the favorable outcomes on other indicators of payment adequacy suggest a conclusion that payments remain adequate through 2005.

Looking then to 2006, the first consideration is that we no longer need a technology factor in the update because MMA has introduced a new tech add-on payment for inpatient services which is not budget neutral and we already had a non-budget neutral add-on on the outpatient side. Then our productivity adjustment is normally based on the 10-year average improvement in total factor productivity in the general economy which currently stands at 0.8 percent.

Last year we recommended a full market basket update in light of the projected negative margins and uncertainty about continuation of cost pressures that hospitals may face. Again this year, we have draft

recommendations for full market basket update on both the inpatient and outpatient sides. But there are several points to consider in making your decision that come out of our presentation today. That the current level of cost increases is basically unsustainable. That private insurers have not been contributing to cost containment in recent years. That the rate of hospital cost growth may be coming down in 2004 and beyond. And that other important indicators, particularly access to care, quality, volume and access to capital, all are quite positive. In light of these factors, you may want to discuss the possibility of recommending an increment below full market basket for our recommendation.

I would also remind you that in conjunction with the payment update, pay for performance would result in a larger share of the money going to hospitals that achieve high quality scores. Many hospitals would end up with a net impact that's less than the across the board update but Medicare would be providing high quality hospitals with an increase at or above the update while sending a strong signal to lower quality institutions.

Our last slide presents the two draft

recommendations. I don't think that we need to take the time to read them. Pending your discussion this morning both call for updates equal to market basket. These recommendations would follow existing law as they stand, so there would be no impact on baseline spending and they should not have major implications for beneficiaries or providers.

MR. HACKBARTH: As I see it, the big picture question for us, and more importantly before the Congress, is what is Medicare's role in this environment where we see costs per case increasing faster than revenues per case and hence not just low margins but a steep decline in the margin? And do you believe that an important factor in the rapid increase in cost is happening on the private side?

In that set of circumstances, is Medicare's role to exert pressure that isn't coming from the private side with the goal of trying to stem the increase in costs per case? Or increase its rate of payment in order to try to accommodate the rate of growth in costs and thus stabilize the declining margins? I think that is, at the end of the day, the question it needs to be addressed. And I think Ralph has a point of view on that.

[Laughter.]

MR. MULLER: First of all, I found this information very helpful and fascinating. Let me talk a little bit about the cost and talk directly about Glenn's other question.

For example, a big part of the cost of any hospital, over 50 percent, are staffing costs, and they're 50 or 60 percent of the average. Usually the biggest proportion of those costs are for nursing. One of the things that happened in the '90s, under all the cost pressures that are outlined in Jack's slide, is that many hospitals around the country experimented with trying to substitute other staff for nurses. There's been very persuasive recent literature by Linda Aiken and some of her other colleagues at the University of Pennsylvania that have both indicated that outcomes across hospitals are better when one has better staffing ratios. That's seen some efforts in some states around the country to legislate higher staffing ratios.

But furthermore, that if you have more RNs as a proportion of your overall nursing population, and even beyond that if you have more bachelor's prepared and

master's prepared. So really that having more professionally qualified nursing has a direct effect on patient outcome.

And since one of the broader themes that we have is what are we paying for and pay for performance, having clear evidence that better prepared nursing staff has better outcomes is one of the reasons that the costs are going up because the effort to move towards getting rid of nurses in the '90s, both turned out to be bad patient care in terms of measuring outcome.

So I think one of the reasons that, in fact, one sees some cost increases that are above the norm, above the rate of inflation, is hospitals are moving back towards hiring more nurses and there's competition for nurses. And as basic market theory will tell you, when people are trying to hire more nurses, more RNs, more bachelor prepared, you're going to have some inflation of that.

Secondly, as we know, there's been a very considerable increase in malpractice. As the chapter indicates, malpractice is still a modest proportion of the overall budget but still when it's going up 20, 30, 40 percent a year over the course of several years, it starts

having an effect on the overall cost structure. Most of that cost increase is not because there are more malpractice cases but the average cost per case has been going on.

I think there are some very appropriate reasons that costs have been going up more than the market basket. I can go further on that. I don't want to go through the whole litany today but certainly the effort to put nursing more in the center of patient care with demonstrated effects of quality is one of the reasons that hospitals have tried to respond to the evidence that the efforts to go on the other direction in the '90 had very adverse outcomes for patients.

Secondly, to go to Glenn's question about the relationship between how we look at the private market and Medicare, we have over the course of the last several years been looking at total Medicare margins as the best indicator of payment adequacy. I think Glenn, you yourself and the staff have been very forceful in arguing that we should look at total Medicare margins and we should not look at total margins. I think it's useful to have this information on total margins, to wit by looking at the private payer market. But in general, we don't look at total margins as

part of our Medicare payment adequacy calculation.

And as I've said in the past, if we're going to start looking at total margins, which in fact I think we implicitly do by looking at what's happening in the private market, then we have to consider whether we're going to do that across all of the categories in the Medicare program. For example, there's 30 years of evidence that Medicaid programs have squeezed nursing home payments. So if we're going to start looking at total margins and whether Medicare has an obligation to either compensate or not compensate for want either Medicaid is doing or private payers are doing, I think we have to look at that issue not just in isolation here.

So I think moving from a basis where payment adequacy has been determined by Medicare margins to one where we take into account the private margin, I think is useful information and obviously, as I've said before, there seems to have been a lack of discipline in the private market over the course of the last few years. I think that lack of discipline has come from a lot of causes, both the patient and political rebellion against managed-care in the late '90s, the fact that private employers and plans and

providers have, in a sense, been able to move those costs on. And whether one starts that reaction against those increases by looking at the providers I think is the wrong place to start. One should look as well at what is happening on the plan side and what is happening in terms of what employers are doing. I know we've had other conversations about that.

But whether it's the role of this commission and Medicare to make up for the lack of discipline elsewhere, it obviously has to be understood. But in the past we have said Medicare payment policy should be based on Medicare margin. So I'm hesitant to start moving off it just when it's convenient.

DR. SCANLON: Ralph, I interpreted the information from the private side somewhat differently. I didn't think we were really moving away from the principle of Medicare margins but more using that as information to understand what might be driving some of the cost growth or facilitating some of the cost growth. And I think that's important because the margin is the product of both the revenue and the cost side and we need to understand that.

I think as I mentioned before, for me,

particularly in the hospital sector, the fact that it's dominated by nonprofit institutions whose obligation and mission is to serve their communities, I think it's incumbent upon them to invest in their communities and therefore to spend the money that they receive. So depending upon how much is available, I think that's going to influence the costs that we do observe.

Having said that I don't think we're moving away from focusing on the Medicare margins, I would say that I believe that we should be thinking over time about moving away from focusing on the average margin alone. Maybe that's too strong of a statement, that we've been focusing on it alone but giving it so much attention because to me I think the distribution of margins, the distribution of the financial status of providers is something that is a more appropriate focus.

We started with PPS in 1983 and we started off giving great deference to the average, assuming that everyone that was below it was more efficient and everybody above it was less efficient. We got away with that, in some respects, because there was enough slack in the system. But the reality is that it's only an average and it's not an

average that's adjusted for all other relevant factors that might influence a provider's ability to provide services.

And ultimately we've got to come back, as we do think about being an efficient purchaser, come back to the issue that our goal is access for Medicare beneficiaries. And our goals should be access at efficient prices. They may not be possible to have efficient prices by simply having a national average with a very limited number of adjustments.

So I think focusing on the distribution of margins, who are the winners, who are the losers under the current system, trying to understand more about why both are in the situation that they're in, and then potentially starting to introduce differential adjustments. This is revolutionary, like pay for performance is revolutionary. But it's potentially that we're at that point in time where we have taken enough slack out of the system. We have enough budgetary pressure on Medicare that we need to start thinking about that.

MS. BURKE: I don't necessarily disagree at all, Bill, with what you've said. But I think would be an overstatement to suggest we haven't, to a certain extent,

done that. We have, in individual cases and individual years, dealt with individual sets of hospitals, must notably the rurals, where we have in fact isolated them and, in fact, -- and I don't mean this in a pejorative way -- but have bailed them out quite directly with fairly substantial amounts of money. Not that I don't love rural hospitals, because I do.

But I think there is a history there. I think you're absolutely right. Those of us old enough to remember 1983, you're right. We began with this presumption of the average and we moved from there. But there's no way in the world you can describe what has occurred between then and now as having stuck to that with any religious fervor at all. We've gone in and intervened whenever someone thought it was important to do so, whether it was with DSH or with IME or with the rural bailouts.

So I think you're right. I think we need to be more thoughtful about it. We need to be more specific about it. It is clear we need to move in that direction. I do support you in that respect. But I don't think to date we've ever really stuck to the averages in any consistent way.

DR. SCANLON: That was why I back tracked from my first statement about focusing solely on the average. I think we have moved away but we've moved away with really very broad brushes. And I think that we may be at the point in time where we really need to be much more discriminating in terms of how we make adjustments and particularly how we update payments over time.

DR. WOLTER: I guess I would say I'm a little bit concerned about the balance in the text on this in terms of the thesis that the inability of the private sector to control costs is really sort of driving all of this. Just to piggyback on a couple of things that Ralph said, in my organization between 2001 and 2004 our malpractice premiums went from $3.5 million to just over $11 billion, which is basically our entire bottom line. When drug eluding stents were introduced, even with the fairly rapid response by the Medicare system, our net in the cath lab dropped by $1 million just because revenue to cost, based on the increased cost of those devices, was quite a bit different. And then of course, the labor issues and the nursing wages.

I think there are some real factors driving costs that aren't just related to the lack of discipline in the

private sector, although maybe that is also an important factor. So it would be nice to at least acknowledge that, I think, in the text.

And then I would say that whatever, this is a very broad brush and there are very significant regional variations in how this plays out. In states like Montana, only 40 percent of businesses even provide health insurance. We have, for all practical purposes, one commercial payer. We have very little ability to cost shift into the private sector relative to some larger urban areas where economies are stronger and there are Fortune 500 companies. We tend to have a higher Medicare percentage.

So the payment update mechanism is a very blunt instrument and it will have differential effects across the country, depending upon those dynamics. And it certainly would be, I think, much harsher in areas like mine than it might be in other areas where you don't have that ability to cost shift.

And then I wonder how the private sectors folks do respond to this because certainly their costs and premiums in many ways are driven by the costs going up that they're seeing. And some would argue that's underfunding in the

public sector, not so much lack of discipline. But I would certainly let them comment. I just wanted to introduce those comments.

And then lastly, I do worry about moving away from the update framework we've used in the past. My feeling is that if we have a framework we've used and it would indicate a certain uptake, but we can't afford it, we ought to say that maybe we can't afford it as opposed to stretching the arguments in a different direction.

Just a couple of more things quickly, Glenn, two really. I'm very concerned about moving away from the technology update. I think that the technology updates that are referred to are very specific to new devices. They do not cover things like the introduction of clinical information systems. I don't believe that even with the recent wave of grants we've done anything but touch the tip of the iceberg of what it's going to take to fund the important wave of technology coming down the road. The $138 million coming out of AHRQ, for example. To put that in perspective, we're a small organization. The system we're now introducing was a $10 million decision. As a percentage of the $128 million, you can see what that represents.

I think that it would be very important to maintain that technology update, personally. Perhaps it ought to be tied a little tighter to actual implementation of something. That might be a suggestion. But I really worry about removing that at this very important time.

Lastly, I say this every year so I'll go ahead and do it again. I don't think there's any evidence whatsoever that there's differential cost allocation into the outpatient sector relative to the impatient sector. I wish we could stop saying that every year. I just don't think it exists anymore.

MR. HACKBARTH: I just want to pick up on one of Nick's points and that was the one about ignoring a well established framework for making these decisions. I agree with that. I don't think that we want to abandon, for the sake of convenience, a framework that we have developed and tried to adhere to. I really feel lousy about that.

I think the question is, or the issue is, that our framework is a fairly elastic one. It doesn't produce a single right answer. Just to be particularly clear about it, it doesn't base decisions solely on margins, either at a point in time or a trend. I think we've taken great care

over the years to say that the margin analysis is one piece of information. We look at other factors like access to capital, which I'm not sure Jack spent much time on today. But in the paper there was a lot of evidence about the rapid increase in capital expenditures. I'm sure there are lots of legitimate reasons for that and we can discuss that.

But the important point is that this is not a one dimensional framework that we've been using that says well, you look at the margin and then you make a decision. I think we look at a lot of different factors and they are pointing in different directions right now and don't lead you to a single obvious answer.

DR. WOLTER: That's why I went through some of the counterpoints, I think, in some ways to the general theme in the chapter. Because again, I think in regions like mine when you see small businesses dropping insurance, that's just another piece of information that if we're going look at the total picture, not just Medicare margins, we need to have all of that in our minds as we make these decisions.

MR. SMITH: Thanks, Glenn. Three brief comments.

First, on are we shifting away from the framework. It's interesting I've been one who over the years has been

critical of the reliance on Medicare margins for a variety of reasons. But actually, Ralph, I don't think we've departed as much this year from that as you would suggest, except in a different way. That there is a lot in here which thinks about, and I think appropriately, Medicare in the larger context of the way the whole health care system is organized and the way payments are structured.

That raises a very interesting question, sort of what's our responsibility? The implicit responsibility suggested by the staff's work is gee, we maybe the only anchor to restrain cost growth here in an environment where the private side has come unglued. Is it our responsibility to try to restrain cost growth, not just for taxpayers but for all bill payers?

That is a bedeviling question but it shows up in sector after sector after sector. I think that's the departure here, rather than asking that question is the departure, rather than a shift in margin. We probably ought to talk about it a lot more.

Second, I find Bill's comment provocative in part because I found the persistently low margin data that Jack and his colleagues presented particularly provocative. The

suggestion in the written work and in our conversation last month is that this is a management problem, that there are a series of hospitals with persistently high negative margins. And what they have in common and what the sources of those persistently high negative margins have in common is crummy management.

Bill, you're right, this isn't one-size-fits-all and some of the distributional data, geographic and size data, suggests that. But I'm more intrigued with the data that suggests gee, there really is a big difference in the way these places are run and figuring out how to target on that big difference may be the most valuable thing we can do.

And lastly, a question. Why no productivity adjustment to the market basket suggested this year?

MR. ASHBY: I think that's the open question.

MR. HACKBARTH: In the draft recommendation? Again, draft recommendations is basically a carryover --

MR. SMITH: Is this a test to see whether we'd notice?

MR. HACKBARTH: No, actually I think Jack pointed out that that was a part of our normal framework, if you

will, that was not present here.

MR. SMITH: What I was asking was a little bit more, Glenn, of what was the thinking behind that departure?

MR. HACKBARTH: Last year, the draft recommendation is where we were last year. You'll recall the basic rationale for market basket last year was just the extraordinary uncertainly we faced, both in terms of what was happening on the cost side and that trend, but also on the revenue effects, the complicated revenue effects of MMA. So we said we'll go with market basket. But now the issue is back squarely on the table of whether we ought to include it this year.

It actually occurs to me that we've skipped over one change in our normal framework. Our statutory charge was amended. As you recall, we talked about this at the retreat. In the list of factors and what we are to consider in making update recommendations, language was added to make it clear that the Congress wants us to consider the costs of efficient providers, as opposed to just average providers. That is a change in our framework.

MS. DePARLE: Haven't we done that? That language is familiar to me from our discussions in the past.

DR. REISCHAUER: Rhetorically, I think we have but analytically we haven't.

MR. HACKBARTH: And to me that's in part where the persistent loser analysis comes in and you look at the people who are losing not just in one year but chronically losing money on Medicare business. Why is that? Is it because they're less efficient, less successful, less well-managed institutions?

DR. WAKEFIELD: A few comments. First of all, on Ralph's point about nurse staffing and issues around that in terms of cost. The quality data that you showed us at the very beginning, one of the areas that it seems we're not doing so well is in the failure to rescue concept. I'm not sure how that was operationally defined across those particular --

MR. GREENE: Actually, failure to rescue is defined by the mortality rate associated with patients who develop complications in the hospital and that's one where we actually were doing better.

DR. WAKEFIELD: Was it? Okay, thank you.

MR. GREENE: That's consistent with the mortality findings.

DR. WAKEFIELD: Never mind.

The point I was going to make is I think that issue is tied to nurse staffing and the way it's been operationalized in some studies. That was going to be my point.

A couple of issues related to the handouts that we're looking at for the first time. First of all, to Sheila's point earlier about rural hospitals and the bailouts. I just would want to make a small clarification and that is that a lot of the provisions that were enacted as part of the MMA were -- does it surprise you that I'm going down this track? I know, take a recess and we'll have a little conversation here.

The point I was going to make is that a lot of the provisions that were enacted as part of the MMA were actually supported, of course, by this Commission empirically. So there was empirical data to look at, equalizing the update factor, affecting DSH, low-volume hospitals, et cetera, et cetera. I just want to make the point that rural hospital administrators aren't out there buying Lamborghinis just yet on that. And I don't think that's what you were saying. I'm only reacting to the

bailout part of that.

MS. BURKE: Poor choice of words. Assistance provided.

DR. WAKEFIELD: Empirically grounded provisions, thank you.

So a small point but a couple of other points I want to raise based on what I'm looking at here.

Jack, it seems to me that at least in the text we're drawing a conclusion about what's within the control of the administration of a hospital linked to what their competition is in their region linked to margins. My concern, of course, was hospitals with negative margins.

The question I've got is that we drop out critical access hospitals and that, it seems to me, is not factored in here. I don't know where we're at yet but we might be at about 1000 hospitals now. I guess my question to you is do you have a sense at all, how are we drawing this conclusion when we're taking that set of hospitals out, trying to get a better understanding of what's within the control and what we're tagging is within the control of hospital administrators? That's one question. I've got about one or two to follow.

The second question that I've got for you, again on the data we're looking at I think for the first time right now, is that the outpatient margins really a double-digit negative on the charts. That, of course, is where a lot of small hospitals do a lot of their business, on the outpatient side. So that's concerning to me. I'll couple that concern with what you were suggesting in your remarks about where we might be going in terms of the provisions related to home health, that the expirations on home health as well as the corridor protection for outpatient and impact that those two provisions may be having on hospitals viability. I'll hope that at some point in time we can come back to that, not necessarily today obviously. But we can better understand what's going on there because that's where so much of the business is done in rural hospitals. That's a real concern. That's more a comment.

The last question I've got is there's one slide here where you're talking about -- let me see if I can find it. The statement if hospitals with above average standardized costs held their cost growth to 2 percentage points above market basket, the 2003 margins would be 2.3 points higher. It seems to me, if I'm looking at the slides

correctly, that brings urban hospitals up slightly into a positive margin, Medicare margin range. Am I looking at that correctly? But it doesn't pop your rural hospital category up into a positive margin. Rural hospitals are still negative, if I'm doing the math correctly on that. Am I?

MR. ASHBY: Let me just comment on the latter one. In terms of averages, you're right, it would pull urbans above zero and not rurals. We don't really know how it would play out, though, if we simulated it by hospital. We applied the same factor to all of them. So we're not really quite sure how that would play out. I think it's probably a bit of a leap to say that the averages would hold here.

DR. WAKEFIELD: So it could be misleading either way?

MR. ASHBY: It could be. We'd have to go a step deeper in order to answer that question.

Then back to the negative margin analysis for a moment, I just wanted to point out that on the one hand it is true, we did exclude CAHs from the entire analysis. We did that only because they are outside of the PPS for which we are developing an update recommendation here.

But we did want to point out, though, that despite CAHs being omitted, the analysis showed that rural hospitals still had neighboring facilities, neighboring PPS facilities that is, within 15 miles. And compared to those competitors, those with the chronically negative margins were uncompetitive, as it were. They had higher costs in the absolute and had lower occupancy. So there are some differences their despite CAHs having been omitted.

DR. WAKEFIELD: Is there anything else you can comment on related to the two provisions that expired and how you see any of that playing here? That is, the outpatient transitional corridor and home health.

MR. ASHBY: Just to acknowledge that they were the key factors behind the decline in negative margins, which was felt particularly on the outpatient side. So it's an issue and it may well be one that we may want to look into in future rounds.

MR. HACKBARTH: In fact, I think we ought to take on another look at that. Mary, can I make one amendment on your initial statement about our support for the rural hospital provisions? I agree with 99 percent. I take pride in that piece of work. I think it was very good MedPAC

work.

But just for accuracy in the record, in a number of instances Congress went further than we recommended and actually adopted some changes in that rural package that were inconsistent with MedPAC recommendations.

DR. WAKEFIELD: Did you notice, Glenn, that I spoke only to our scope of work and our contribution? It was deliberate.

MS. DePARLE: I had a couple of comments. First, I thought the work that we've done this year on the hospitals with consistently poor or negative Medicare margins was really fascinating. Today, in particular, I heard some data that I had not heard before about the way in which those hospitals may drive our perception or what the numbers look like in terms of overall Medicare margins for all hospitals. I thought that was really interesting. I hope we will spend more time on that.

One of the things you noted was that also associated with those hospitals is a lower occupancy. I guess I would be interested in knowing more, in a more granular fashion, whether that also is a proxy for -- well, to what extent are there or are there not access problems

for Medicare beneficiaries in the area in which these hospitals operate? I suspect that there are not. I suspect they may be overbedded, as I would define that. I think that would be interesting to know. And I think this work is very important as we look toward the future.

MR. ASHBY: Let me just elaborate on what we already found on that. The chronically negative margin hospitals averaged about a 47 percent occupancy, compared to I think it was 58 percent for the hospitals in their markets. I think we can all recognize that that leaves considerable room for patient care to be provided. So there wasn't any immediate indication of access problems.

MS. DePARLE: I know we don't have a surfeit of excess staff or resources, certainly not know, but that might be an area where we can do some of the visits that we've tried to do in the past, on other sectors, to just go into a market and really drill down a little bit more and see what's going on. I think it's really fascinating.

Secondly, on our update recommendation and the extent to which it is or is not a mathematical formula, I think we all agree here it's not a mathematical formula. There is a judgment that goes into deciding what it should

be. But on the question that's on the table of whether we should decide this year for a full market basket for hospitals or something less based on our judgment about the way things are trending within the hospital sector or larger budgetary and deficit reduction issues, I guess my concern about doing that, my concern about deviating from the draft recommendation that you have on the screen here is that I think we are not looking at -- if we were going to do that I would want to look at the full context of Medicare spending.

Glenn, you said at the beginning of this session, we had discussed earlier that we are not going to be making recommendations, for example, on Medicare Advantage. There are some other areas also that we're not covering. And with respect to Medicare managed care in particular, with that being $40 billion, I guess that Medicare is now spending on that, and with some quite significant changes that have occurred as a result of the Medicare Modernization Act that will potentially increase that spending, we haven't spent time really studying that here. But that makes me less inclined to consider the overall budgetary context when we're looking at these individual fee-for-service providers. I think I would be more inclined to look at all of that

together if we were going to bring in what is, I think, sort of an extraneous factor to look at here.

DR. MILSTEIN: I think if we're going to move forward and refine our recommendations to reflect the costs of so-called efficient providers, I would hope that we would define inefficiency within two different frames of reference. One is the efficiency of hospitals with respect to the cost per stay. And secondly, efficiency of hospitals with respect to total Medicare costs incurred in the 12 months following a hospital discharge. What's nice about this with respect to the staff burden is the government folks have already down a lot of these analyses for us.

The latter definition of efficiency obviously exerts much more leverage on overall Medicare cost growth. And so I would hope that it would, at a minimum, be equally considered in determining the update required by efficient hospitals.

DR. STOWERS: I just want Mary to know that I would never use the bailout word.

For those rural additions that were in the MMA, I'm just going to ask Jack, are they figured in here at all? And some of those did apply to other urban and so forth. So

when we say that rural is going to be minus 6.2 or whatever, is that taking into account those changes?

MR. ASHBY: Two issues, rural is not going to be minus 6.2. In the projection it was minus 3.1 and that very definitely does take into account all of the provisions that are in the MMA.

DR. STOWERS: So it was just 6.2 in 2003 but taking those into account it goes up to the into dust and three by taking those that he goes into the 3.1.

DR. REISCHAUER: But not the critical access hospitals.

MR. ASHBY: Right, critical excess hospitals are outside of the analysis.

DR. REISCHAUER: They took a big chunk out.

DR. STOWERS: So then when we add the update on, we're getting closer? Is that counting the update?

MR. ASHBY: The projection from 2003 to 2006, first of all, takes into account MMA provisions or really all payment provisions that are scheduled to go into effect. But it also takes into account the updates between 2003 and 2005 that are already in law and our projection of cost growth during that period. So it's an attempt to be all-

encompassing, if you will.

MS. RAPHAEL: I had a technical question, Jack. I noticed in your chapter on nursing homes that we went back and adjusted the market basket. I don't know if I understand it correctly, but the update was adjusted at a later point in time where there was some additional amount added to the market basket.

MR. ASHBY: That was the forecast error provision for SNF updates.

MS. RAPHAEL: Does that all pertain to --

MR. ASHBY: That was not pertain to the hospital industry. That was a specific legislation provision for SNF.

MR. HACKBARTH: And that's not something that we ever embraced or recommended. That was something that Congress included in MMA.

MR. ASHBY: It wasn't MMA.

MR. HACKBARTH: So it was done administratively.

DR. MILLER: They got the full market basket and then the change was administrative. CMS made the correction that added another 3 percent or 3.2 or thereabouts to it. So the net impact on year was 6-plus percent.

MR. HACKBARTH: Okay. We are finished with this.

We will have a five to 10 minute public comment period. Because of the time constraints, forgive me if I interrupt. We really have a lot more stuff to go through this afternoon. So please keep your comment brief and, in addition, if anybody before you in line has made the comment already, don't feel obliged to repeat it.

MS. COYLE: Thank you very much, Carmela Coyle with the American Hospital Association. One comment on pay for performance and one on the update.

I want to thank the Commission for their work on pay for performance. As everybody is looking at this issue, a lot of resonance on the concept but some real challenge as to how you apply this in a government payment program.

I would like to suggest that the Commission may want to consider some discussion in its chapter around what is one of the most important connections here, I think. And that is as you're looking at making recommendations about the size of the performance adjustment and the time line, it's so connected to which measures will ultimately be used. A lot of reference to the 10 measures currently being used as part of the voluntary hospital reporting initiative. As

you all may know well, those are all process measures. The equation, I think, changes and could change quite dramatically if you consider structural measures or outcomes measures and would just ask that you may consider that.

Being a participant and a leader in the hospital voluntary quality initiative also, would just like to share both the spirit of the collaboration of that effort. It's been great. But also the sobering experience, the literally daunting challenges of the data collection, the reporting, the validation of the data and all the rest that goes with it, I think, for all of us, CMS, the Joint Commission, AARP, AFL-CIO, has been a slower process than any of us would have like to have seen. So I just offer that up.

On the update, one comment and that is this conversation on the meaning of low-margin data. It has been suggested that it may be attributable to management problems. I would just like to reflect on the fact that we have many hospitals who have high Medicare margins but lower negative total margins. Yet their cost structure in the efficiency is the same. the importance of recognizing the policy issues, patient acuity issues, payer mix issues and trying to understand what a negative margin means.

The commission staff presented, for the first time in some time, a look at the hospital field that shows negative performance under the Medicare program. I think it's the most important finding of today. It was not in the materials handed out but we were all scribbling dutifully. The margin trend has been negative and has now been negative since 1999. That is a four-year negative trend. And we think that's important and would ask the Commission to consider it, as well as the fact that Congress did make its recommendations on the update for both 2005 and 2006 in consultation with many stakeholders after just one year of that, which includes the experimentation some quality reporting. I think it would be unfortunate to move away from that after just one year's worth of experience.

Thank you.

MR. SPIEDEL: Hi, Paul Spiedel with the Medical Group Management Association. Thank you all for your efforts on the pay for performance matter. It's a very important topic.

One specific comment on recommendation number five, extracting quality data from Part D claims. I believe I heard staff suggest what one quality data you might

consider looking at is whether or not the patient has filled the script. It's my understanding that most physician practices do not currently enjoy this functionality. some of the larger groups might, be I think most do not.

Which means there's probably -- well, obviously, it's a significant impact on quality of care. But additionally, it means some work would have to be done to make it happen.

I see two ways you could do that. One, you'd have to have a significant increase in physician and patient communication, which likely would lead to increased office visits, which would impact physician reimbursement through the SGR. Or two, both the physician office and all of the pharmacies that its patients use would have to have fully interoperable electronic health systems to exchange that data, which would require significant investment. So I think it's important to recognize that there would be some significant implications for providers from that.

And that point may be illustrative of the importance of Drs. Scanlon's and Reischauer's suggestion that you examine these things very fully. We're very appreciative of all your work. We know that both the staff

and the commissioners have put a lot of time and energy into this. I think as you look even more closely at some of these issues, you might tease out more of these concerns that might ultimately change your recommendations.

Thank you.

MR. HACKBARTH: Okay, we will adjourn for lunch and reconvene at 1:30.

[Whereupon, at 12:48 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:37 p.m.]

MR. HACKBARTH: Good afternoon. Next up on the agenda are efforts to support adoption of health information technology, and then specialty hospitals.

DR. WORZALA: Good afternoon. I'm here to present our work on efforts to support adoption of health IT. Karen and Chad also worked on this with me. It builds on the work we did last June, lots of discussions with people working in the field, both public and private sector, and our expert panel in October.

Given all the recent activity in this area, your mailing materials did cover considerable ground. Here in the presentation I plan to be brief and focus on areas with the draft recommendations. Feel free to bring up other topics, of course.

Use of IT in health care is well low. However, surveys that many providers are planning to invest. There are many factors that are limiting adoption. These include the cost and the complexity of the market. In addition, the risk of failure is quite a high because successful adoption requires both considerable commitment as well as cultural and work process changes that are difficult to implement.

Finally, the way we pay for health care can result in misaligned financial incentives. This means that the individual testing in health IT may not reap all the financial benefits of doing so. Finally, the technology currently used has a limited ability to transfer data across systems. Realizing the full promise of IT does require addressing this problem as well.

IT has considerable potential to improve health care, which has led many to believe that the government should step in to support IT adoption. There is limited but suggestive evidence linking IT use to quality improvements, particularly for CPOE, bar coding, and clinical decision support systems. There is little rigorous research on efficiency but the anecdotal evidence suggests that certain kinds of IT may improve it.

Research also indicates that a broad adoption of IT that allows clinical information to flow across providers could result in large, system-wide savings. While that sharing of data across settings does not currently happen very often, once developed it would probably help with coordination of care. Finally, as the private sector and Medicare move toward greater accountability for quality, IT

will become a valuable tool for performance measurement.

So while the case for government support of IT is building, we should be mindful of certain risks as we evaluate efforts to do so. As we've discussed previously, IT investment is generally risky. Therefore, to the extent possible, government funds need to be well targeted.

Second, government actions could have unintended consequences. We've heard that successful implementation requires very strong commitment to change. Supporting adoption where that commitment is absent could actually result in failures that set us back rather than moving us forward. Also, as a principle, the government minimize interference in what is essentially a private market. Finally, we need to recognize the physical constraints that are presented in our context chapter.

Your briefing materials review a number of actions that the private and public sectors could take or are taking to support adoption of IT. We have chosen to organize them according to three goals. Those are, helping the IT market develop, providing financial incentives, and encouraging sharing of information across providers and patients. I will touch on the actions that are being thought of and some

current efforts very briefly. Where additional actions seem warranted we have proposed draft recommendations. I'll circle back to those at the end.

The health IT market is constantly evolving. It is also very technical, so providers do not always have the knowledge or the resources that they need to assess their needs and navigate the market. A number of very important efforts are underway to address this problem targeted primarily at physicians in small and medium-sized practices.

First, in consultation with HHS, the private sector has begun an effort to certify IT products. Certification should yield information on what these products can do and increase providers' confidence in choosing among them. Other organizations are involved in technical assistance for providers, helping them to assess their names, choose products, and implement work process change. Specialty societies are doing this, and within the Medicare program some QIOs are doing so as well.

Given the barriers of cost and misaligned financial incentives, there may be a need to provide financial incentives for the adoption of IT. I'll come back to the role of pay for performance in a minute. Grants and

loans to individual providers for their IT systems have been mentioned as a direct way to lower the cost of IT adoption. However, the cautions we spoke of earlier might make large-scale grants and loans of this type risky for the government. They do little to address difficulties of implementation and also risk displacing private capital. On a more limited scale, however, grants can provide lessons learned, and both the government and private sector have been giving grants, with AHRQ recently announcing $139 million in grants over the next few years.

One of the promises of IT is to make necessary clinical information and decision support available at the time care is delivered. Currently, most health information is shared among actors by phone, fax and paper. With IT systems that can communicate across settings, patient history and results of tests that were performed in an outpatient settings could be available in the emergency room. Similarly, changes to medications that were initiated during a hospital stay could be available to a primary care physician along with the notes documenting why.

Getting from here to there, however, takes technical and organizational advances. So what actions can

the government and private sector take to facilitate that evolution?

First, HHS, foundations and others have put considerable effort into developing standards that will allow IT systems to communicate with each other. These standards address things like the content of data, the vocabulary used to describe information, and how messages are sent from one system to another. The development of standards is crucial and the commitment to continue this work is high.

Second, as standards are developed it becomes important to ensure that they are used. I will return to this issue later.

Third, health care is generally a local enterprise, therefore, information really needs to flow between providers within a community. I will also return to the idea of encouraging community efforts a little bit later.

Finally, some have noted that hospitals could be well positioned to exchange data and facilitate adoption of IT by allowing community physicians to utilize their IT systems or by providing them with other IT resources.

However, the Stark and the anti-referral laws generally prohibit this kind of arrangement.

There is a narrow exception to Stark for community-wide health information exchange but it requires, among other things, that hospitals share these resources with all providers in the community, and most hospitals are not likely to want to do this. So we believe the Secretary should revisit the restrictions and provide guidance on situations that do and do not comply with these laws, otherwise the existing regulations could stifle important advances in both information exchange and adoption of IT. The MMA has directed the creation of safe harbors and exceptions for these laws in the context of e-prescribing, which may provide an opportunity to clarify how they may apply to other uses of IT.

Now I will circle back on the areas where we have proposed draft recommendations. You talked this morning about pay for performance and noted that it is closely linked to IT. I just want to let you know that for January we are planning to bring these two topics together in one chapter. It is a bit of a work in progress.

There are a number of ways in which pay for

performance could encourage adoption of IT. First, we could include measures of IT adoption into the pay-for-performance program.

Second, providers may find it easier to report on quality measures using IT systems. This could motivate adoption whether or not specific IT measures are used.

And third, the potential for additional funds from good performance helps build the business case for IT to the extent that IT helps achieve and report on the quality measures.

So what kind of IT measures could be used in pay for performance? There are basically two concepts here. The first is to pay for IT adoption or to include measures of IT adoption, which is really rewarding the acquisition of a tool. We believe, however, that is to reward the positive outcomes that derive from the actual use of the tool, or at least uses that are linked to improved quality.

So that leads to the second concept, which would be to reward functions of IT that lead to improved quality. This approach would reward processes linked to desired outcomes. It would also allow providers to meet the measure with or without IT. I think this is important because

adoption of IT is an evolution and we don't want to limit providers' ability to attain this kind of measure, at least at first. Of course, using IT would make it easier to achieve and report on functional measures, so there is still an incentive for adoption. Over time there is room to move to measures of actual IT use.

The Bridges to Excellence program does use some of these concepts in its physician office link program. CMS is currently working with them and NQF to further develop these measures for use in a demo and to operationalize them. Karen gave you some examples of this kind of measure this morning for physicians. I won't go through those here, but they are facilitated by use of IT and can be done without it as well. In a hospital setting, an example of this kind of measure would be ensuring that physicians check for drug-drug interactions and allergies when placing pharmacy orders. This is really the link between use of CPOE and quality improvement. There you're pulling out the function as opposed to talking about the technology.

So that brings us to the following recommendation. Congress should direct CMS to include measures of function supported by the use of information technology in Medicare

initiatives to financially reward providers on the basis of quality.

Within this recommendation we think the first place to start is the physician setting, given the central role physicians plan in improving quality, and the importance of encouraging IT in this sector. Some hospital measures might be possible, particularly surrounding CPOE functions. Other settings might need more development.

We see no spending implications from this recommendation. For beneficiaries, we would expect some improved quality of care. And of course, some providers could receive higher or lower payments depending on the quality of their care in any pay-for-performance initiative.

I want to touch briefly on some implementation issues surrounding IT measures within pay for performance. First, you do need a process for measure selection an ongoing development, and you do need some coordination between purchasers over measures ideally, and you would want to work with the IT vendors to ensure that their products include the ability to report on and to support the functions in the measures.

The next few slides revisit actions to increase

sharing of data across providers. A major focus of activity has been development of standards and that is a prerequisite to solving the technical issues of how to share data. Nevertheless, there's limited sharing of data across providers at the moment, in part because these standards are not yet in widespread use. Successful implementers, including Geisinger, have noted that physicians place great value on electronic access to information that was generated outside of their own office. That would include laboratory data, radiology reports, and pharmacy data. Having access to this kind of information increases physicians' willingness to accept IT.

However, these providers and also existing community networks have reported that outside information generally is not sent using data standards, and that makes it very difficult to incorporate the information into their own EHR systems or data repositories and to have it available when it's needed. One example of a place where standards are well developed but not widely used is clinical laboratory data. Therefore, we can make a significant step in achieving the goal of sharing clinically important data by encouraging the use of standards in reporting lab

results.

This brings us back to a draft recommendation you discussed this morning, which was that CMS should require those who perform lab tests to submit lab values on claims or separately using common vocabulary and messaging standards. I'll focus on the last clause of this recommendation and also note that as with all protected health information you would also need to ensure the privacy and security of data flows here.

But the idea behind the final clause of this recommendation is that requiring use of vocabulary and messaging standards for data submission to CMS would spillover to use in reporting information to providers since it's much more efficient for the labs to operate using a single set of standards. Then the providers receiving the information can easily incorporate it into their processing EMRs or data repositories, and also share it with other providers that might need it.

Currently, most labs have internal codes for identifying their tests and reporting results to clients. Codes are unique to each lab. However, vocabulary or coding standards, such is LOINC, do exist, and LOINC in particular

has been endorsed by the American Clinical Lab Association, the College of American Pathologists, and it is used as an alternate code set by many of the major labs. It's also been adopted by the federal government for us in its health programs, including by CMS. Messaging standards such as HL7 are also generally accepted.

What would it take to achieve this standard? The first step is to map local codes to the standard codes. This is already being done by large labs and is probably not an insurmountable task.

Second, it's necessary to ensure that laboratory information systems can both accommodate these codes and also transmit them. That may require some work on the part of vendors, although we've been told that many systems already do this.

As I mentioned, larger labs are moving fairly far along this trajectory so it should be easy for them to do this fairly quickly. It may, however, be necessary to have some sort of phased implementation for smaller labs, including those in hospitals and physician offices.

The last area I want to community information exchange. Here we are talking about developing the

organizations and technical solutions to allow information to flow among providers at the local level; physicians, hospitals, and others providers, so it's available when needed.

In addition to potential quality improvements, we could also improve system and provider efficiency through fewer repeat tests, and administrative efficiency. Finally, being part of a local network and really having access to information from other sources could encourage IT adoption by individual providers.

Despite the importance of local data exchange there are few examples currently operational. We did hear about the one in Indianapolis in October. There are many more under consideration and being developed across the country. Some are being supported by grants, such as those that AHRQ has made to five states for development of statewide information exchange. In addition, the strategic framework put forward by HHS this summer discussed the importance of fostering regional collaborations.

So to further encourage clinical data exchange one idea would be to provide additional resources through a loan fund. Criteria for award would need to be established.

Specifics could include the types of providers involved, their level of commitment, including financial commitment, what kind of data they would share, how they would protect the privacy and security of data, and how organizations would work together, and how the projects could be sustained over time. Evaluation criteria could also be developed to further our understanding of what works.

The loan fund could be time-limited, recognizing that we're encouraging, development, not ongoing maintenance. The specific mechanism for the fund could be left to the Secretary to propose. For example, would it be a loan fund actually administered by a government agency or a program run through private banks as is done for student loans?

That brings us to our second and final draft recommendation. The Congress should authorize an appropriated loan fund for support of community health information exchange projects. The spending implications of this are a short-term increase in spending over the baseline. For beneficiary and provider implications there is potential for improved quality and coordination of care, and some providers would benefit from the loans.

MR. DeBUSK: Under the pay for performance examples there it says, ensuring physicians check for drug-to-drug interactions and allergies when placing pharmacy orders, inpatient and outpatient.

This has even more far-reaching advantages. One of the things that is most difficult is all these pharmacy programs. These pharmacies are not hooked together with information. You may have a patient that is getting pharmaceuticals from two or three different doctors and two or three different pharmacies, and by approaching this in this manner this has far-reaching value in trying to begin to straighten up that whole area, because with the cost of pharmaceuticals, and that being such an important part of it, until that piece is cleared up it is going to be hard to arrive where we need to arrive.

DR. NELSON: This is good and I support the recommendations. There are a couple of areas that I think need amplifying.

From what I understand, while a lot of the attention is being given to the cost of the software and the installation, inadequate attention is being given to the cost of maintenance, and the impact on productivity; the

number of patients that a clinician can see in a day. There are data from VA -- I talked to a person in the VA and they said that with the installation of their electronic health record productivity dropped 50 percent, and it's still down.

Now I don't know whether that's across the entire system. I don't know how bid the denominator is. But I think that some examination of the impact on reducing the number of patients that can be seen in a day, particularly during the phase-in period, is important, and some information on that can be gotten from the VA and from some of the public large integrated systems that are utilizing the electronic health record.

I'd like to see some mention of an alternative approach. That is, an open source, web-based electronic health record that is developed and maintained by the government itself, at least for programs for which the government is the purchaser. It seems to me that for patients or clinicians who are authorized to do so, to have access to the electronic health record from any computer that can get into the web would offer a lot of advantages in terms of patients being able to enter data into their electronic health record, their blood test, their blood

sugar results, their blood pressures or whatever. It could avoid a lot of the interoperability headaches if that were developed.

Finally, I'd like to see us make a recommendation about funding the office of the coordinator. Now it may not be timely, it may not be politically prudent to do so, but I think this should be considered, because that's a very important function that currently hasn't been funded.

I heard a physician who is in a system that uses an electronic health record say that downstream he would like to see a study on the number of deaths caused by an electronic health record. It almost certainly would be less than those saved. But practitioners really rely on their medical record, and if they have an office full of patients, maybe some of whom traveled a long way to get there, and their record is down, they are almost certainly going to do the best with what they've got, which is recall. In his view, at any rate, that risk wasn't negligible. Some of those recollections and guesses may be faulty it terms of what medications they are on or so forth.

DR. CROSSON: I will make just a comment on the productivity issue and then the other point that I wanted to

make. We obviously have spent a lot of time looking at this issue. We have had two pilots in place in our northwest region and our Colorado region over five years and we're in the middle of rollout in other areas. So we are looking at this, and as you can imagine our physicians are fairly interested in this issue.

It is complex. One of the things we have found is that there is an initial fall in productivity, particularly for physicians who are not skilled in typing, and there's a period of time during which the presence of the computer in the examination room creates a new dynamic that both the doctors and the patients have to learn.

But what we've generally found is that for most specialties that re-equilibrates back to normal in a matter of weeks, no more than a month or so, with one exception, and that has to do with internal medicine where the complexity of the patients as well as the number of tests to be reviewed and communicated is considerably greater than for other specialties. In some areas of internal medicine I think there is a productivity loss that remains. It's in the category of single digits. But for the other specialties --

MR. HACKBARTH: Remains after five years or after --

DR. CROSSON: I don't know that we've got that but probably for six months or more. That one tends to be related to age also, and practice styles, and learning new ways. But there's a difference between internal medicine and all the other specialties in that regard. But for most specialties the rebound back to normal productivity is pretty quick. I don't know that will be everybody's experience, but that's been ours.

A point on draft recommendation number one. This is complementary to the comment I made this morning in the pay-for-performance area because clearly these are linked and I know there is going to be some more work on that. The recommendation talks about including measures of functions supported by the use of information technology as part of pay for performance. I absolutely agree with that.

But I think there is another point that shouldn't be missed, and really goes beyond that. It goes beyond it in terms of time and implications. In other words, it would be further down the line but potentially they have more implications. And that's that the essence of being able to

do pay for performance and to extend it to large numbers of physicians and to deepen it so that is actually represents a better biopsy of the care, if you will, is really only going to be achieved once the systems are in use generally.

Just to give an example, if you wanted to take a major health condition, high blood pressure, and what we want to do is to have people have their blood pressure taken, and when it's high to have it managed with medication, diet, exercise or whatever. Then we want to know the relationship between that, or the absence of that, and further complications like strokes.

One of the confounding problems is simply that we don't have people's blood pressures. We don't know what they are because they are contained within the medical record. To extract that by having someone go into the chart and read it and write it down and put it into a computer database is extremely expensive. The presence of a medical record where the blood pressure is entered every time the patient accesses care for any reason makes it much more available and at virtually no cost.

So there are examples in many health conditions where you simply can't get -- I suppose you could tack it

onto claims data like other things we've talked about, but essentially it is not just rewarding -- in the beginning it is putting the systems in place or obvious processes that come out of the systems, to a payment system. But eventually it is going to be linked to measuring things which are only accessible through the use of the system, and this would be an example. Somewhere, whether in the text or in the recommendation I hope we can express that because in the end that is going to be where this lives.

MS. RAPHAEL: I wanted to speak to the productivity issue because I think that is an important issue. We had a similar experience when we introduced our electronic health record, which is also tied to the OASIS assessment, because we have a 29-page assessment that we have to do. We did have a drop-off in productivity, but we did rebound, the same point that Jay described. I think there is a period, but I don't think it goes on it definitely.

I would say there is an issue that we had not at all anticipated, which is that some of the patients really say to our nurses, are you taking care of me or are you taking care of the computer? This is my time with you and

it seems to me that all you're doing is recording information in the computer, which is something we had not anticipated. So we have some people who don't point of service, which is defeating what we were trying to do, that they would record all of this real-time, not later when they have to recollect.

So that has been something that we have been trying to tackle, and it is something to keep in mind. Particularly we find it with older patients, those 85 and older who have a lot of issues and really want you to listen to them. This is the high point of their day when you are there. So I do think that is important.

The other point I did want to make is I really believe the most important recommendation is that our loans should be targeted to setting up community health networks, because we are trying experiments now where upon admission a hospital will send us information, or we can electronically exchange information with a physician. It is very powerful. It really makes a huge difference to be able to do that, because patients' situations are changing constantly, and being able to say to a physician, there is a problem with the medication, we think someone needs to come in and see

you, we want to schedule an appointment and really move to do that has changed quality in very tangible ways.

But I don't think those things are going to happen where it's not provider-based without some kind of external pressure. I think that if you want to make outcomes, you are more likely to adopt information technology if you think it is going to make a difference in your performance. But this is an area where I really do think we need some extreme pressure and possible loans.

MR. HACKBARTH: On the computer in the room issue, the experience of my colleagues was that it changed the dynamics, as Jay said. There were some patients who perhaps never liked it, but with other patients it was actually an engaging tool, the ability to graph information, show trends in various lab results and the like over time actually aided the conversation and helped the physician make the points they were trying to make.

MS. DePARLE: I just wanted to strongly endorse what Alan said about amending recommendation one to say something about funding the Office of Information Technology at HHS. If this is as serious as I think we mean it to be and a national priority, that office should be funded.

MR. HACKBARTH: Maybe, Chantal, you should say just a word about that. I know some people have seen the press reports about what happened in the appropriations bill but not all commissions may be aware of where that stands.

DR. WORZALA: My understanding is that the President's budget requested $50 million for the Office of National Coordinator for Health Information Technology or ONCHIT as it's called, and somehow in the appropriations process, although some funds had been included on the House side, they weren't on the Senate side, and in reconciliation it was not included in the omnibus bill that came out. There is funding for the office, I believe to the level of $4 million or something like that. The additional funding was meant to go for grants and loans and contracts.

MR. SMITH: Two quick points, one about a recommendation we did make or we are considering and one that I wonder if we should consider. For all the reasons that Carol said it strikes me that we ought to seriously consider over time, and with care about the pace of introduction, but that we ought to consider having the capacity to manage and update an electronic medical record a condition of participation. Carol suggested that the

incentive here needed to be financial. I don't think we have any evidence that it needs to be financial. There are potential downstream benefits to the investor, whether it is the physician investor or the hospital investor. If we start down that road and learn that there are financial problems, we can address those without any serious loss of pace.

But for all of the reasons that we have talked about for the last year, Chantal, much of what is in the materials that you sent us, it seems to me we ought to up the ante here, and use Medicare's power as a player in this marketplace, to insist that we go down this road. We don't have any more powerful tool than condition of participation. Along with and subsequent to, the development of standards and protocols and interoperability standards it seems to me we ought to say, this is part of what you have to be able to do to participate down the road, and then put a timeline on that.

Conversely, I'd be perfectly prepared to support recommendation two, which argues that we ought to build this community infrastructure and the highways necessary, and that we ought to use public resources to do it, if we had

any evidence that the absence of public resources is the obstacle to getting it done. When the expert panel met with us a couple months ago that wasn't raised as the problem. There were many more institutional relationship problems and universality problems than financial problems.

There is no contrary argument, Chantal, in your presentation that suggests that we've got a real financial problem here. We appear to be solving a financial problem without having argued or adduced any evidence that there is one. So in the absence of that I'd be disinclined to create another load fund. There may be some advantage. I suppose it's a little bit like a tax break, whether or not I need it, I'll use if you pass it. But it seems we ought to make a stronger case that access to financing is the obstacle before we provide it.

MR. HACKBARTH: As someone who's interested in this concept but not yet wedded to it, I do think some more information would be helpful that perhaps we can get from Clem McDonald and some other people involved in this about to what extent there are costs that are difficult to cover. The information we have, there are very few of these community networks in existence and that would suggest that

there may be some problems out there and that not all is well. So let's nail that down.

The reason that I wanted to at least have it here for discussion, and we may decide not to recommend it in January, is that it seems to me that there may be an issue that -- we already have issues with individual providers having sufficient incentive to invest in their own computer system software, work re-dos and the like. To what extent are there additional costs to create a community network over and above those that are truly public goods that may not be developed, may not be adequately invested in without some public support? That's the question, and I'm offering it as a question as opposed to an answer at this point.

DR. REISCHAUER: Do we have evidence that the average provider in a community like Indianapolis, there's a higher acceptability of IT and the use of this if one of these networks exists? Because it strikes me that there might be an externality here. There might not be a financial barrier, but if you put some money on the table it what happen faster and the benefit of it would be a more rapid spread of something that we think will improve health care.

DR. WORZALA: I think that's a good point. Just a couple quick comments on that.

First, I think there is a real cost to this. There are very few of these things around because it is hard to have a collective effort where you have a collective tax to do something that will support the public good and the collective good, but who will bear the cost? I think it's a fairly classic area where public investment is needed. I will certainly go out and talk to Santa Barbara and Regenstrief about their cost. These are multi-year developments of projects that, I know Regenstrief, for example, is funded by a foundation. So I will certainly bring you back information on that. But there are clearly costs there and they go over several years. Again, it's something where it's very hard to tax individuals for something that ends up being a collective good.

MR. DURENBERGER: My comment was going to be on the context. I don't necessarily see this as a stand-alone subject. Anybody can address it, and it gets to be a little bit like the elephant. In the context of the real problems we have in front of us, this needs to be hooked to performance in some fashion, be it a subset on one of the

tools like profiling or resource use or something like that so that we build a case for it.

With regard to the Indianapolis example, and I've been there a couple of times and I've known Clem a long time and I was there a couple -- I think you should go. I don't have all the answers.

But the answer to Santa Barbara and the answer to Indianapolis is people in the community who realized that both the cost and the quality of health care had to change, made the decision, and developed the dynamics in that community to make things happen. It was a combination of having a Regenstrief with the clinical informatics pioneers right there to give you the language and to encourage you to think this is not like trying to send a rock to the moon and things like that. It was also the presence of major companies in the medical field that were willing to invest, not because they had products involved but because they had employees all over the community that in one way or another would --

Then it was the primary care doctors, and this network is referenced in here. And it was community health centers. It was just linking up -- not starting at the top,

the high expense stuff, but they were linking up primary care, they're linking up community health centers. And then it was a very creative Medicaid director in Indiana with a lot of pressure. And I have heard her say many times, the only way to keep the cost pressures off of Medicaid is to enhance the quality of the performance of the system, and that's why we're in it.

So it is in that context that I would love to see us present the role of information technology. When I looked particularly at that second draft recommendation, that comes right out of the 1960s; let's create a loan fund and let's scatter money around the country and things like that. Indiana valued getting one of those of five grants from AHRQ because it was recognition. Not because they had to have $50 million or something like that to make something happen, but because it was recognition that this cross-section of the community was about to do something that was unique in the country.

So the ultimate decision it seems to me, whether it is Indiana or wherever it is, is going to be a combination of motivation and incentives, and it is going to come from the community up, because every one of these

hospital systems can make these decisions. Then the question will be, will the health plans raise the money to help them, or do you have to waive for the federal government to do it? So if in some way we can express that it is an important thing to do but not try to suggest that the national government has some responsibility to make it happen, but in effect to find out what is its most appropriate role in facilitating this for the purposes that we think as a Medicare program, whether it's physician practice or whatever.

MR. HACKBARTH: One of the differences between a loan and a grant is that if you take out a loan you need to have some sort of plan for how you are going to pay it back, as opposed to I got money and I'm going to spend it and we will see what happens tomorrow. So ideally what you would have with a loan program is people developing a business model of how somebody can take over responsibility for sustaining this, and charge a fee, and collect revenue that allows them to service the loan and make it into some sort of a business. That's the notion I have in my head at least of how this might go.

A couple people at different times have raised the

issue of the interrelationship among these various topics. They are just all over the place, the connections and that is important for us to try to get right. I thought I heard you say, Chantal, that ultimately this information will be packaged in the pay-for-performance chapter; is that right?

DR. WORZALA: Yes.

MR. HACKBARTH: I'm glad to hear that. I think that is a critical link. As I've said and many other commissioners have said often, having this information infrastructure is going to be a critical, if not maybe the most important determinant of how quickly we can move down the pay-for-performance path because it will address the cost of information issue. So it's good that's going to be combined.

DR. WAKEFIELD: I really like the orientation toward community and the focus that is put on that, both in the background material that we were provided and also in your overview here. I don't know if you've had a chance to take a look at it or not but the Institute of Medicine released about a month ago a new report as part of their quality series focusing on health care in rural America and improving quality. There's an entire section of that report

that talks about IT.

It talks about potentially some of the opportunities for moving, maybe even more expeditiously in some rural communities, with a community-based orientation. But it also talks about some of the unique barriers and obstacles that are absolutely present in some rural areas and not so much in urban areas. So I would just hope that that informs the thinking and the layout of at least some of the text where you think it makes sense to reference it in the document that does go forward. It's brand new and captures a few key concepts.

With regard to the loan recommendation, I don't know that you can get there but it does seem to me that to the extent that there could be any sort of targeting of that -- and I don't know that one could do that -- but that we ensure that those communities and organizations that are in greatest need actually have access to some sort of financial support that will allow them to move on the IT front. Particularly because, to the extent we do link that to payment policy we've got to make sure that they can get their on the front end.

Some of the examples that you gave in the text

that are very good, the AHRQ example with grants was a grants match opportunity. I know personally of facilities that would have loved to have gone there but financially, at least at that point in time, their perception, they couldn't match. So if there's any way that we can frame this to a way of targeting this toward those most in need that might be something to think about.

Also when I think about loans I'm thinking about, if they couldn't match then how are they going to compete for a loan? And is there a way to think about or give a nod to loan forgiveness? For example, if X is accomplished, or something is tied to this investment in terms of performance and quality, then could a piece of that loan be forgiven on the back end? That's probably more complicated than we can get into here, but holding organizations absolutely responsible for achieving outcomes if they have access to any public funds, and then recognizing that maybe that degree of need isn't the same across-the-board.

DR. WOLTER: This is really a nice chapter, Chantal. I think the areas you identified where policy can advance technology, really outstanding, so my next comment is a nit-pick. That is on page 18, given the scope of

existing grants, more may not be needed. Relative to what I said before, I think really the total of grants thus far is minuscule in the context of what is really going to be needed to implement technology.

Now it may well be that there is capacity in the industry, as David was suggesting, although I would argue that that is pretty uneven capacity, and I think there are many places, whether it's small physician offices or smaller hospitals that are going to be very hard-pressed to come up with this funding. I am actually quite certain of that. So I'd make a pitch again as we look at our update framework going forward that technology piece may continue to be important although we may want to tighten up how it is linked to actual implementation of technology.

Just a couple other things. I can't emphasize the importance of some increased flexibility in Stark and kickback regulation, because if there is some capacity on the part of large players to work with physician offices or to work with smaller rural hospitals, these right now are such huge barriers. In fact if I'm remembering the community hospital presentation from Indianapolis, they're still gun-shy about how to promote access amongst the

players until they have some of that sorted out. That's well-stated here already but I just wanted to emphasize that.

Also if we're going to move to interoperability, the whole issue of standards and getting vendors to realize that they really need to be making the move toward interfaces and other abilities to deal with legacy systems really is important.

Then lastly, the whole intersection with the privacy and security regulations is critical as well. We are running into a lot of difficulty implementing our system across the region as we work with other facilities, in terms of who has access, how do we protect privacy and security, what additional software has to be purchased to allow us to run audits. There's a huge cost there and a huge area of regulation to comply with, so that's another important issue.

DR. MILSTEIN: I think the direction of the chapter is terrific and I'm very supportive. These are really a couple of suggested tweaks, and you can probably guess in what direction, and also a couple questions.

First of all, I think the need to specifically

incentivize IT is a symptom of the fact that we have a long ways to go in terms of incentivizing the right things in the Medicare program. If we were incentivizing the right things then you wouldn't have to separately incentivize IT.

For example, if you look at the analysis of return on investment, it's whoever is reaping the benefits of greater longitudinal efficiency that benefits primarily from IT, especially for smaller physician practices. If we were incentivizing smaller physician practices for superiority and longitudinal efficiency then it would completely change the economics of return on investment in IT and it would make sense for them to do it.

I support the prior notion that the reward of IT-enabled functions should be short-term and I would vote for very short-term rather than intermediate short-term. I really like the idea of going to very quickly incentivizing performance or incentivizing a fully interoperating electronic health record. I'll come back to that in a minute.

A second comment is some of the negative productivity effects that have been described that are associated with implementing IT in a particular physician

office setting, those effects are usually measured without regard for new IT-enabled opportunities to further re-engineer clinical processes. Once you've got a good, smart EHR operating, that enables you to take quite a few low-risk ambulatory interactions and allow medical assistants and nurse practitioners to do them. That's seldom factored into the equation that suggest that this is a major impediment to productivity.

The third area is maybe just a question. We incentivized in our recommendations one facet of interoperability standards. That is we focused on the labs. I'm curious why we didn't focus on the other facets that the Secretary of HHS has already endorsed. I'm thinking about DICOM for imaging. If you are going to bill for an imaging study, why not -- you might have some DICOM-formatted results that go along with it.

Lastly, and this really ties into my first comment, if we do, sooner rather than later, incentivize interoperating rather than interoperable, interoperating IT systems, then you don't need to then subsidize the start up of these networks. The private sector can see that if within four years it becomes a Medicare condition of

participation to have an interoperating EHR, then the private sector can -- then the capital needed from the private sector to respond and build these EHRs, because they know they have a lot of customers within four years of stepping forward. So it does reduce the need for setting up the additional grant program.

DR. WORZALA: Just a quick comment on the lab. I think you need a vehicle, and I certainly support the notion that you need to move from laboratory to other sources of information too. But since we have this recommendation on the lab value, that gives us the vehicle. But I will beef up the discussion of other types of information flow as well.

MS. BURKE: I agree, it's a terrifically useful chapter and gives us some serious things to think about in the context of what we're trying to do in moving this forward.

Having said that, I in fact would not support this recommendation, for a variety of reasons. It is not in any way to suggest that I don't think it is important that we clearly state our desire for an increase in the amount of information that is exchanged, or in the need to invest in

the technology and systems necessary to allow that to occur increasingly.

I oppose it for a couple of reasons. One, it may just be a timing issue. But as I read the chapter, you cite about $150 million worth of investment in this kind of activity that has already occurred. The department has the authority to invest. You see the Department of Agriculture is invested. There are a variety of other sources that are invested. I think the likelihood in the near term of an appropriated account being created that would be anything close to $150 million, given the current budget concerns, is reasonably unlikely. Not because it is not an important issue but because of all the other issues that are confronting us.

I also think that creating loan programs bring with them a whole series of issues about how one chooses among different priorities in terms of the allocation. The administrative complexity of running a major program bring along a lot of issues that force lots of politics to play out in terms of how one might go about allocating that.

I think we can achieve this in a different way, and I think more realistically, at least in the near term,

through using what mechanisms are currently available, and also looking to the private sector. Again, it is not that I don't agree with what we're hoping to do nor that we ought not incentivize people. We've talked about a lot of issues with respect to the update factors, with respect to the adequacy of the payment and how we are asking people to do things and creating incentives for them to do so in terms of the payment system.

I just don't think at this point in time that this particular proposal makes a great deal of sense, nor is it likely to be realized in the near term. But I think we ought to look at other ways of creating the same reality through existing programs or through flexibility that the Secretary currently has. But setting aside essentially rifle shots, freestanding appropriated accounts, is a tough thing to do, and I'm not sure that right now is the time that I think the Commission ought to be in fact suggesting that as compared to looking at other ways to achieving the same end.

DR. NELSON: I didn't want my earlier comments to be misinterpreted. I understand the importance of IT in reconfiguring the way health care is delivered, and I fully

support that. Obviously, the downstream potential for increased productivity is there as teams are developed and so forth. But for the solo and small-group practitioner, particularly in primary care, their concern is what about next year? The up-front investment and the decreased productivity may be enough to determine whether they can stay in Panguitch or whether they have to move to Salt Lake, and that should be important from the standpoint of our mission.

MR. HACKBARTH: Thank you, Chantal.

Next up is specialty hospitals.

MR. PETTENGILL: Good afternoon. In this session we're going to talk about some further results and draft recommendations for the mandated specialty hospital study which is due in March. In previous meetings we have discussed the first four topics listed on this slide. Now we would like to turn to potential solutions for some of the problems that we have identified. I will talk about potential changes in Medicare's prospective payment system and Ariel will then talk about other non-payment options.

At the October meeting we demonstrated that the payment rates in Medicare's hospital inpatient prospective

payment system result in large differences in relative profitability across and within DRGs. These differences in relative profitability create financial incentives for hospitals to specialize in relatively profitable DRGs, and also to select low severity and relatively low-cost cases within DRGs.

These relative profitability differences arise in part because of a failure of the DRGs to fully account for differences in severity of illness that affect the cost of care. This problem might be addressed by making severity refinements to the definitions as we have illustrated using the all-patient refined DRGs.

Differences in relative profitability also arise because of problems with the relative weights. One problem with the relative weights is that they're based on charges which reflect systematic differences in markups for ancillary services such as laboratory services, imaging, or supplies compared with the markups for other services. This problem might be addressed by substituting cost in place of charges as the basis for the weights.

An additional problems is that standardizing charges, as we do now, to eliminate differences in cost

across hospitals is not fully effective. This problem might be addressed by using relative value weights instead.

A third problem is that charges for most cases that are paid as outliers are included in the calculation of the DRG relative weights. This causes the weights for high-cost categories to be overstated because that is where the outlier cases are concentrated. This problem could be remedied by reducing the weights for each DRG DRG proportionately.

To evaluate these potential policy changes we simulated their effects using our file of more than 10 million claims. We used our inpatient prospective payment system payment model for fiscal year 2002 to estimate the payments for each claim. We also used previously developed estimates of cost for each claim, which were based as you recall on taking charges and reducing them using the appropriate cost-to-charge ratio from the hospital's Medicare cost report for the same time period.

We couldn't simulate every possible combination of these four changes so what we did is we selected the combinations that are shown on this slide with the idea that we could show the effects of each policy individually and

also show the effects of logical combinations of policies. Perhaps the smallest change that you might make would be to use hospital relative weights in place of standardizing the charges with no other changes. We took that as the first model.

The second model adds severity differences to the DRGs, but the weights are still based on charges and the outlier policy remains as it is currently.

The third model adds cost-based weights in place of charge-based weights.

The fourth model then adds DRG-specific outlier offsets. In the last case we did not run a full simulation of this model. We had done that in 2000. Instead we estimated a rough approximation, but we believe that this approximation gives a good indication of what the likely effects would be.

For each model we focused primarily on two issues. One is payment accuracy. How would the policy changes affect differences in relative profitability across and within DRGs? How would they affect the extent of favorable selection now enjoyed by physician-owned specialty hospitals, for example?

The other issue is the impact on inpatient payments to hospitals. These policy options would not affect aggregate payments under Medicare because the Secretary is required to maintain budget neutrality when changing the DRG definitions or the weights, and that's what these policies do. But we would expect these policy options to affect the distribution of payments among hospitals, so it's important to know how much.

We also addressed some administrative burdens associated with these options, and I will return to that later when I talk about some of CMS's administrative concerns.

Now let's look at the results on payment accuracy. This chart shows how the policy options would change hospitals' opportunities to gain or lose up from specializing in certain DRGs. The bars indicate the shares of payments that would fall in DRGs that have national relative payment-to-cost ratios lower than 0.95, shown in gold, greater than 1.05, in pink, and in between in green.

The middle bar basically tells the story. Under current policy the payments are pretty evenly distributed across those categories. As you add each policy change, the

differences in relative profitability compress toward one, which is the national average. Under the fourth model at the far right, 86 percent of the payments are in DRGs that have relative profitability ratios within plus or minus 0.05 of the average.

If you were to look at what happens to relative profitability ratios for APRDRG severity classes, that is within DRGs, then you would see that opportunities for selection within DRGs also diminish as we move across models. These same patterns are reflected in each DRG, which you will see next.

This table illustrates for DRG 107 what I just told you overall. For this DRG relative profitability, which is 10 percent above average under current policy, falls to 1.0, the average, when all four policy changes are included. The effects of adding the policy changes are similar for virtually all DRGs whether they start off above or below one.

Now let's look at what happens to opportunities and incentives for selection with DRGs across severity classes within the DRG. The bottom four lines on this table show the relative profitability ratios across severity

classes under each model. Under current policy Medicare patients in severity classes one, two, and three are relatively attractive on average because their relative profitability ratios are greater than one. Adopting relative value weights would not have much effect on hospitals' incentives for selection because you can see that relative profitability ratios don't change much.

But as you would expect, adding DRG refinements, which means calculating a separate payment rate for each severity class within a DRG, that action would substantially diminish incentives for selection across the severity classes.

Now note how the hierarchy of relative profitability across severity classes reverses when we add DRG refinements in the second model. Patients in classes one and two, which were relatively profitable under current policy, now would be less relatively profitable. This reflects the treatment of outlier cases in the weights and the uniform financing of outlier payments. When differences in outlier prevalence are addressed in the fourth model, this hierarchy of relative profitability disappears, and along with it, measurable opportunities for selection.

Note also in the last column that relative profitability ratios for severity classes don't always encompass the overall average. We checked this out because it was a little disturbing. In part it is because the APRDRG severity classes do not match the DRGs one for one. The concordance is more complicated. These severity classes include about 5,500 cases that are from other DRGs than 107. When you pull those cases out and look at it again it does now encompass the overall average. It also could reflect some of the limitations of using our rough approximation for model four rather than a full simulation.

Now I'd like to turn to what the policy changes would do to patient selection at the hospital level. This table shows what happens to expected relative profitability for hospital groups. The measure tells us what a hospital group's expected relative profitability would look like given its mix of cases if all the hospitals in the group had national average relative profitability for each APRDRG severity class. Thus, it indicates the extent to which hospitals have a favorable selection of patients across severity classes.

Physician-owned heart, orthopedic and surgical

hospitals all have a favorable selection given their mix of cases under current policy. Other groups, however, do not have a favorable or unfavorable selection on average. As we move across models, expected relative profitability diminishes for physician-owned specialty groups but it remains essentially unchanged for other groups. The results for community hospitals here are somewhat misleading, however, because many individual hospitals within these groups would have either a favorable or an unfavorable selection of patients under current policy. You just don't see it here because you are looking at the average.

Note that selection on average turns relatively unfavorable for orthopedic and surgical hospitals under the third model. This again reflects the treatment of outlier payments.

Now I'd like to turn to the impact on inpatient PPS payments among hospitals. Although I'm not showing it here, the impact on payments at the group level reflects essentially what you see here. There's a strong tie-in between selection and payment.

If we reduce the relative profitability in DRGs that have high ratios now, payments for the hospital that

have lots of cases in those categories are going to fall. It is as simple as that. Thus, payments would decline progressively more under each model for the physician-owned groups. The average decrease for physician-owned heart hospitals, for example, would reach almost 10 percent under model four. For broader categories of community hospitals, payments would remain essentially unchanged on average. But again, remember that's somewhat misleading as you'll see in the next chart.

This table shows how all the policy options combined in model four would affect payments for individual hospitals. This is different from the table that we sent you in the mailing. At the time we didn't have these estimates for model four so we sent you model three. The numbers here show the shares of hospitals in each group that would fall in different intervals of the percentage change in payments. As you can see, payments would decline substantially for physician-owned heart and orthopedic hospitals because they have lots of patients in the DRGs or severity classes with high current profitability ratios.

For community hospitals, payments would fall for hospitals that have a favorable selection now, but they

would increase for hospitals that have an unfavorable selection under current policy. The size of these changes suggest that a transition policy would be desirable in implementing these policies.

These findings lead us to offer the following draft recommendations. In developing the draft recommendations we've separated the potential policy changes based on the limits of the Secretary's authority under current law. In this recommendation we're talking about actions that the Secretary can take now. We have a separate recommendation for changes in the outlier policy which would require legislation.

The Secretary should improve payment accuracy in the hospital inpatient PPS by adopting three refinements. The current DRGs should be refined to more fully capture differences in severity of illness among patients. The DRG relative weights should be based on the estimated claim-level cost rather than charges, and the weights should be based on the national average of hospitals' relative values in each DRG.

The second draft recommendation concerns the outlier policy. The Congress should amend the law to give

the Secretary authority to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases. Note that this would mean financing outlier payments through proportionate reductions in the weights rather than through the current 5.2 percent uniform reduction in all payment rates.

The third recommendation recognizes the need for a transition. To mitigate the impact on providers, the Congress and the Secretary should ensure that the case mix measurement and outlier policies recommended earlier are implemented through a transition.

The implications of these draft recommendations are shown on this slide. They would not have any effect on overall Medicare spending because the Secretary is required to maintain budget neutrality. But the devil is in the details, as it is always is, and the actual budget impact here might vary depending on how CMS deals with potential increases in payment that result from potential upcoding, and also on exactly what sort of a transition mechanism is adopted.

These policies should have little or no impact on beneficiaries, but as we've seen, adopting these policies

would change the distribution of payments among hospitals, raising them for some and lowering them for others.

Finally, I'd like to turn to the administrative burdens associated with these policy changes. We've spoken with CMS staff and we tried to think of ways to address some with their concerns. These policy issues raise important concerns primarily related to DRG refinement and to using estimated costs in place of charges.

One concern is that DRG refinement could result in many groups with small numbers of cases, and potentially unstable weights. We are not endorsing the APRDRGs with their 1,400 groups; just using them to illustrate the kinds of gains that CMS could achieve. The refinements should be made selectively, taking into account differences in costs across the categories and also the numbers of cases involved. Much of the potential benefits of refinement might well be achieved without adding a large number of groups.

Another concern raised by CMS relates to increases in payments due to coding. This problem is real, but in the Benefits Improvement and Protection Act, the Congress gave the Secretary the authority to make a prospective adjustment

to the standardized payment amounts to offset anticipated increases in payments resulting from upcoding. The Secretary hasn't used that authority to date, but CMS has a dataset of re-abstracted medical records that could be used to make projections of the extent of any likely upcoding.

A third issue is how to make refinements without rewarding avoidable complications. You discussed that this morning in the context of pay for performance. This is that issue of identifying conditions that were present at admission on the record. I don't think I have anything more to add to that than you discussed this morning.

There also issues related to the burden and timeliness of using estimated costs in place of charges. It is hard work, as I can tell you. We think that one way to limit the burden might be to compute cost for claims periodically and then use the relationship between the cost weights and charge weights to adjust annually-computed charge weights for an interim period until you re-estimate costs again, perhaps five years later. That would solve a lot of the concern about burden.

Now Ariel will discuss non-payment options.

MR. WINTER: Even if CMS were to make these

improvements to the inpatient payment system there could still be inequities between physician-owned and non-physician owned hospitals. Thus, I will be describing options to reduce these inequities by revising the section of the Stark law that governs physician ownership of hospitals. I'll also discuss the potential for gainsharing arrangements to better align physician and hospital financial incentives.

To quickly review the Stark law, it prohibits physicians from referring Medicare or Medicaid patients for certain services to a provider with which the physician has a financial relationship. However, the law allows physicians to refer patients to hospitals in which they are investors as long as their interest is in the whole hospital rather than a hospital subdivision. This is known as the whole hospital exception.

Over the last several years a growing number of physician-owned single specialty hospitals have emerged. The MMA placed a moratorium on the development of new physician-owned single specialty hospitals to which physician investors refer patients. This expires in June 2005.

We've previously discussed with you the concerns with physician referral to hospitals that they own so I won't spend too much time on these points. Briefly, the main concern is that physician ownership may improperly influence their professional judgment. It could create financial incentives to refer patients to the hospital owned by the physician, which may or may not be best for the patient. It could also create financial incentives to recommend additional services with high expected marginal profits, such as heart bypass surgery. There's also a concern that physician investment could create an unlevel playing field between facilities because physicians influence where patients receive care.

On the other hand, advocates of physician-owned hospitals have argued that they provide more efficient and higher quality care. However, the evidence we presented in November shows that most physician-owned hospitals do not have lower Medicare inpatient costs. We do not know whether they provide better quality care.

These concerns lead us to the following draft recommendation.

The Congress should eliminate the whole hospital

exception in the Stark law for all new hospitals and direct the Secretary to develop criteria for grandfathering existing hospitals. This would prohibit physicians from referring patients to new hospitals in which they have an ownership stake, whether they are single specialty or full-service hospitals.

It would allow physician referral to pre-existing physician-owned hospitals, but the Secretary should develop criteria to prevent the excessive expansion of these hospitals. For example, by developing subsidiaries or bringing in new physician investors. We expect that Congress would make this change retroactive to the end of the moratorium to prevent a growth spurt of physician-owned hospitals when the moratorium expires in June.

One question is whether to make an exception for new physician-owned hospitals in rural areas. Almost 20 percent of the physician-owned hospitals that we identified are in rural areas. Each of these areas currently has at least one community hospital, so access does not seem to be a problem. We'd like to get your feedback on this question.

In terms of spending implications, we estimate no effect. We think there would be a small effect on providers

because it would prevent physicians from referring patients to new physician-owned hospitals. And we estimate no impact on beneficiaries.

In developing this recommendation we considered two other options but decided to not propose them. One was to protect a minimal level of physician investment in hospitals. We felt, however, it would be difficult to determine a level at which professional judgment is not affected. The other idea was to prohibit the referral of patients to only single specialty hospitals owned by physicians, but we thought it would be difficult to draw a clear line between single specialty and full-service hospitals. I'd be happy to take questions about these two ideas at the end.

The next topic we will discuss is gainsharing arrangements in which hospitals and physicians share savings from cost-reduction efforts that involve physicians, such as reducing the use of unnecessary supplies and ancillary services. We believe that gainsharing could better align hospital and physician financial incentives, but could be structured to have fewer risks than outright physician ownership of hospitals.

The potential benefits of gainsharing include encouraging hospital and physician cooperation to deliver care more efficiently, and countering the silo effect created by separate payment systems for physician and inpatient hospital care.

However, there are some concerns with gainsharing. The OIG has ruled that gainsharing violates a legal provision that prohibits hospitals from offering financial incentives to physicians to reduce services to Medicare patients. This was meant to prevent hospitals from paying physicians to discharge patients quicker and sicker under the inpatient payment system. Thus, gainsharing arrangements could harm the quality of patient care depending on how they're structured. They could also create incentives for physicians to refer patients to the hospital with which they have the most lucrative financial arrangement.

The OIG recognized that gainsharing has the potential to improve care and reduce costs as long as there are proper safeguards. HHS needs the statutory authority to develop these protections. So here are some ideas for safeguards which are based on a gainsharing arrangement that

was approved by the OIG.

There should be measures to protect quality of care. These could include specifying the cost-saving actions that are to be undertaken, and setting a threshold for the appropriate use of services. There should also be measures to minimize financial incentives that might affect physician referrals. An example would be basing potential savings on physicians' prior-year admissions, which would reduce the incentive to increase admissions.

Thus our final recommendation is, the Congress should grant the Secretary the authority to regulate gainsharing arrangements between physicians and hospitals so that quality of care is protected and financial incentives that could affect physician referrals are minimized.

We estimate no impact on spending. In terms of provider implications, this would allow providers to deliver care more efficiently and there is the potential to improve the quality of care for beneficiaries.

This includes our presentation and we'd be happy to take any questions.

MR. HACKBARTH: If I may let me start with an observation. I have no problem whatsoever with competition.

In fact I believe in competition and I think that in the course of our discussion of this issue and the case studies we have seen evidence that competition can stimulate needed improvement. Moreover, specialization to me is not a problem, per se. I believe the thesis that specialization has the potential to improve quality, improve efficiency, improve patient satisfaction, and improve physician productivity. I don't have any problem believing those things.

As we've gone through this research and discussed the issues, my big concerns here are about an unlevel playing field, where we have competition but the rules of the gam are different. And we have competition but we have a payment system that is sufficiently inaccurate that some type of organizations can win, potentially at the cost of others and at the expense of the community.

So what I'm about here is trying to figure how we can preserve competition, have the right set of rules that allow the competition to proceed fairly and with the maximum likelihood of benefit to patients, the community, and the Medicare program. It's not about being against specialization, per se.

I think it might be helpful if we could have our discussion on the two parts, the payment issues first, and then second on the gainsharing and whole hospital exemption, just to allow us to focus the conversation a little bit. So let's start with the payment issues.

Any questions or comments about that work?

DR. SCANLON: I couldn't be a card-carrying economist if I was against specialization or competition so I would agree with you completely. I think we have in the analysis of the payment system, the DRGs, identified that we really have created an unlevel playing field, so the movement to correct that is something that is appropriate in this context but it's also appropriate more generally for hospitals overall.

There's one other thing that we haven't talked about in terms of the unlevel playing field and that is a problem that is fundamental to the health care system and that's the information imbalance between patients and providers. That's what I think relates to the part of the recommendation in terms of removing the whole hospital exception. Because patients, frankly, rely upon physicians for helping them make the decision as to whether or not they

are going to get services and there's an inherent conflict of interest that exists. I know that most physicians don't exploit that conflict but we do need to be concerned that it's present in marketplace and it distorts decisions that we see. So I think we should keep that in mind as well as we're thinking about the second of these recommendations, because fixing the payments does not change the nature of that.

MR. MULLER: I think the work the staff has done here is incredibly helpful because while we have all suspected over many years that there's a lot of variation inside the DRG system, to actually specify the magnitude of it, and especially how deep the differences among the severity classes I think is a major advance in our understanding. So I am in favor of the recommendations towards doing the kind of rebasing that allows us to have a system, which has a lot of flaws that we discuss all the time, but have a system that more fairly represents the true cost of care.

As we've said at other times as well, we shouldn't have a payment system that basically advantages those who select patients adverse to provide care. So if the art in

the process is to select patients of less severity and get paid very handsomely for it, that undermines the whole payment system. Again, an imperfect payment system but it's the one that we have. So taking away that advantage I think is of importance so that in a system that pays on average we continue to reward people for providing care to the full spectrum of patients rather than rewarding them for selecting a subset of those patients. So I'm in favor of those kind of recommendations.

I know you want to separate the recommendation so I will come back later on the other matters, but I share Bill's concern that we have now shown evidence that this selection bias that I'm speaking is exacerbated when there's ownership issues involved. So I think we need to deal with those forcefully as well.

If you want to do it in that sequence I'll come back later. Thank you.

MR. HACKBARTH: Other comments on the payment issues?

DR. STOWERS: I just want to be sure that we really do make the point that this readjustment of the payment system affects all hospitals. We have it bury in

the middle of this specialty hospital chapter. I'm not sure that came as much as it should.

The second thing is, in light that it does affect all hospitals -- I hate to be Mary here this morning and talk rural hospitals, but just by the mere nature of community hospitals they're going to be taking care of the less severe APRDRGs inside the DRGs, I would think. So I'm just curious if we've taken a look down through, and if that might lead to the thought that if it does should we be focusing more on the code sets in the beginning that are affecting the specialty hospitals like the orthopedics or the cardiac until we are really sure about what the unintended consequences might be in other settings. I'm sure you've thought about it. I was just curious what you were --

MR. PETTENGILL: We have looked at that and this is the relevant table, and rural is the middle column in the bottom section. What you can't see there is that the overall average change in payments for rural hospitals is plus 0.5 percent under the fourth option. What you can see here is that you have got 33 percent in the one to five positive category and 16 percent in the more than five; 17

percent in the middle, which is basically negligible effect, and then 25 and eight on the downside. In fact there are quite a lot of rural hospitals that have an unfavorable selection of patients now and that would be remedied. There are a somewhat smaller number of all hospitals that have favorable selection and that would be remedied as well, and they would lose money.

DR. MILLER: But that effect could also be coming from the outlier policy shift as well, right?

MR. PETTENGILL: This includes all four policies.

DR. MILLER: That's my point, is that there could be a selection effect that is showing up here, but also an effect from the outlier policy.

MR. PETTENGILL: But in effect that amounts to a selection effect, because what you're doing is charging them for outliers when they don't have them.

DR. MILLER: I just want to be clear that there's a couple -- when we are using the word selection most people are going to immediately think about complex and less complex patients, and I think he's making a point about that. But there are other parts of this policy like the outlier that could have a beneficial effect for some set of

rural hospitals here, looking at the right end of the distribution, which I don't think most people think of as selection, although I do understand how you are speaking of it.

DR. REISCHAUER: Can I just talk a little about these numbers? It seems that we have a Lake Woebegone effect in the sense that while it's budget neutral, over 50 percent are in the top half of the class, so some of these things -- these are institutions not weighted by revenues.

MR. PETTENGILL: That's exactly right.

DR. REISCHAUER: So let's not get too excited without knowing how much of the market we're really talking about.

MR. PETTENGILL: Some of my colleagues when I first showed this slide noticed the same thing and they said, this can't be true. By in fact it is. If you look at the share of payments that fall in each interval and you put that together with the average percentage change for hospitals in each interval and you multiply the two together and get the weighted average, it comes out exactly the same as the overall effect.

MR. HACKBARTH: Can I offer a couple additional

observations about this table? When I first saw it it immediately occurred to me that independent of the specialty hospital issue what this table says to me is the system is out of whack. Even if we didn't have the specialty hospital phenomenon at all we'd be wanting to refine the payment system.

MR. MULLER: I think Bob's point, if we go to slide eight it shows why with that 47 and 27 on the left, there's such an advantage to having the low severity patient when that gets adjusted there's a lot to spread back over to the other hospitals. That's how I explained to myself the phenomenon you noticed.

MR. HACKBARTH: The second observation about this, if you're a member of Congress and think about the amount of money that's being redistributed here, it is daunting. We can do transitions and that sort of stuff but this is big stuff. This is very important and will have significant impacts on the system.

The other way to look at that is the big numbers are also an indicator of how urgent it is to do. They are a sign of how maldistributed the dollars are right now. So I think this is just a critical piece of work.

MR. SMITH: Building on what you just said, I think there needs to be a recommendation four in the first half of this, and that is until recommendations one through three are fully implemented the moratorium ought to stay in place. That these distortions are so extraordinary, and at least anecdotally folks are waiting at the door to attenuate the distortions on July 1, looking at these numbers makes it clear why competition and specialization are good ideas. But the playing field is not level and it's not going to get level until the first three recommendations are implemented and we ought to keep the moratorium in place until that occurs.

DR. REISCHAUER: When you did this you are adjusting all the DRGs to the APRDRG system?

MR. PETTENGILL: Yes.

DR. REISCHAUER: You said that staff at CMS said, this is a daunting exercise. I was wondering if you went through DRGs if in a lot of them you wouldn't find quite this amount, or in some of them you might find very small amounts of variation, and the simplification would be to take the top 50 or something like that in terms of dollar value of effect and move forward that way and you'd get 90

percent of the correction that is necessary. Or maybe that is not true.

MR. PETTENGILL: I think typically the way it works is if you look at the difference in costliness between severity class one and severity class two, sometimes the difference is not all that great. So you would say, given the variance in cost within the groups it's not worth speaking the distinction.

Similarly, sometimes the difference between three and four is not that great and you would probably say that one we could throw away without losing much. There will be other cases where -- remember the APRDRGs were defined for all patients, not just Medicare patients, so there a lot of categories in there that are for patients under 17, or for maternity stays and things like that. So there are a lot of categories that you could throw away almost like that.

DR. REISCHAUER: But there must be also some which there are very few people in some of the categories.

MR. PETTENGILL: And differences are big? Yes, there would be some like that. There you would have to make a judgment about whether to make the distinction or not. You might in that case want to look at a couple of years of

data to see whether the relationship is strong and stays stable from year to year.

DR. MILSTEIN: One of the learnings from the last three or four years of more frequent clinical reengineering within ICUs is that hospitals that have gone through that successfully have enjoyed very substantial reductions in the frequency of outlier patients. I just raise as a question for further staff evaluation whether or not we ought to think about slightly modifying recommendation two to, instead of adjusting for differences in the hospital's actual prevalence of high cost outlier cases, to instead think about accounting for differences in a hospital's projected prevalence of outlier cases based on the illness burden of who's coming in the front door, so we do not find ourselves inadvertently rewarding hospitals who, due to less success in managing more severely ill patients end up with a large number of outliers.

Our ability to do that or our confidence in doing that should be substantially increased to the degree our previous recommendation from the morning is adopted. That is that Medicare requires as a condition of payment coding of a secondary diagnoses with respect to whether or not

they're present on admission. That will substantially lift our ability to assess patient severity of illness at the time of admission.

DR. CROSSON: Just to jump on board, I think the rebasing of DRGs, the need for that screams from the data. There's no question about that. The question I had Bob already asked so I'll have to think about that.

MR. HACKBARTH: Let's turn to the recommendations on gainsharing, the whole hospital exemption, and also I'd include here what Dave has raised about the moratorium. I would welcome comments on those issues.

MS. DePARLE: My comment was about the moratorium. I was flipping through the pages of our document to see -- I couldn't remember whether Congress even asked for our opinion on this. But it does seem to me that given the evidence that's been presented to us and that we've been talking about the last few months that it would be a shame to open this back up again until these issues get addressed. So if it's appropriate for us to make a recommendation on the moratorium I would agree with Dave that we should recommend that Congress extend the moratorium until they are able to deal with these issues.

MR. MULLER: I agree with Dave and Nancy-Ann on the moratorium and I also am in favor of draft recommendation four, again for some of the same reasons, that we shouldn't have biases in patient selection being a key part of the system. Obviously we're looking for access for patients. We shouldn't be rewarding people for how they select, so I'm for recommendation four as well.

DR. REISCHAUER: While I agree with the thrust of what David, Nancy-Ann and Ralph have that said, I worry that if we just say keep the moratorium in effect until these other changes take place, the other changes might not take place. While they scream to us, there will be people who scream when they are put in place. I would be much more in favor of extending them for whatever sounds like a reasonable length of time for the Secretary and CMS to do this job, but to leave their possible disappearance as a threat that would push reform forward.

DR. CROSSON: I'm going to offer a little contrarian perspective here on the whole hospital exception thing. I think we heard early on from the staff interview process that there were really two reasons brought forward for physicians engaging in ownership or partial ownership of

the hospitals. One was the obvious one and perhaps the overriding one, was in fact an opportunity to profit from the successful hospital. But another one that was also fairly prominent for certain physicians and groups of physicians was to try to establish an environment which better fit with their practice style. And particularly the issue of efficiency, not so much of the hospital itself which was examined here, but the efficiency of the physician's practice itself; having an operating room available at a time and place and a nature that fits with the practice and the like. We saw that pretty prominently in the interviews.

The problem is disentangling those two motivations, and it is not possible to do that for human beings most of the time. But I thought as we went along in the discussion that there might be a way to do that. For example, the idea of limiting the gain that an individual physician or group could see from this kind of ownership might do that, not in absolute way but potentially in a substantially mitigated way. I understand the objections that are raised to doing that. It is complex, particularly the issue of group ownership versus individual ownership

makes it harder to figure how you would do that.

But I do have some concern about simply removing the whole hospital exception because then there will be a loss for some physicians of that potential opportunity to have that practice environment, and potentially to engage in a kind of constructive competition, if you will. In other words, if you could somehow get rid of the unbalanced incentives by rebasing the DRGs, and in fact get rid of the substance and perception of conflict of interest for the physicians then you'd have essentially a marketplace phenomenon of an arguably efficient hospital, more satisfying to the physicians, perhaps arguably producing better quality and the like. The question is, is that possible to do?

I just wonder whether or not -- and I'm fully supportive of extending the moratorium to date certain until we get to a point where the DRG rebasing could take place. But I just wonder whether in the context of a final recommendation we could spend some time -- for example, I could imagine, to go back to the mechanism that brought about some of the nation's medical groups in the beginning, an environment in which physicians could create, for the

purposes of holding partial ownership in a hospital, a not-for-profit community benefit organization which would in fact remove that part of the incentive and yet still allow partial ownership by physicians for the purpose of having influence and creating the kind of practice environment. That or something like that is the mechanism that created, years ago, the foundation model which led to some of the group practices.

MR. HACKBARTH: I may be not following you, but if in fact they use the vehicle of a not-for-profit entity --

DR. CROSSON: Just for the physician ownership piece, not for the hospital itself.

DR. MILLER: So the way I understand the mechanism, you're saying that the physicians could have ownership in the hospital. Their ownerships would be organized in a not-for-profit foundation. There could be other investors that would just invest as a regular investment, and anything that the physicians realize out of the investment stays with the non-profit foundation, which is headed to the purpose.

DR. CROSSON: Yes, community purpose. I'm not advocating for that. I'm just saying that it might be

worthwhile prior to the final recommendation to explore that and other possibilities to essentially separate those two physician goals, and if that were possible we might end up in a different place.

MR. HACKBARTH: Unfortunately we're not going to have time to engage in a lengthy discussion of this today, but as we work through these issues over the next month we can talk about those ideas. To the extent that we change the profitability of the DRGs that will reduce some of the incentive to go down the whole hospital exemption path and physician ownership. To what degree it will reduce it I don't know, but it will diminish the potential gain.

I am equally drawn by the gainsharing idea because I do believe that there is something to the idea of aligning, giving physicians and hospitals the opportunity to work together and achieve gains together and share the benefits together. We've heard that as one of the motivations for owning your own hospital. I think that ought to be generally available within defined boundaries, and hence the recommendation for legislation authorizing gainsharing. I think that could be quite constructive for the whole system, for not-for-profit hospitals to have that

opportunity, particularly at the threshold of the pay-for-performance era when getting physicians to work with hospital administration is going to determine how successful these efforts are.

So the short answer is we can look at some different configurations of these several pieces.

Other comments?

DR. WOLTER: I think this is excellent work and I am really very supportive of the recommendations. I think the gainsharing also is very important.

I was wondering if in the recommendation we could promote a little bit more actively that promotion of quality is part of how incentives might be supplied as part of the gainsharing, so that it's cost-reduction but it is also actively working on promotion of quality. Clearly that could involve payment to physicians and should, and we could maybe be a little bit more explicit about that.

A little bit like Jay I'm wondering, does there need to be some conversation about group practice exceptions related to ownership of these types of facilities, because there are organizations where payment to physicians is totally benchmarked in different ways, totally separate from

how the services and reimbursement comes into the organization. We do have those exceptions in some of the other Stark regulations, so we may want to think about that nuance.

We may also want to think about suggesting that hospitals be more active in including physicians in operating councils or governance activities of some of these services because I think that gets to some of the issues Jay was referencing as well.

MR. HACKBARTH: The issues surrounding the Stark law are very complicated issues and that's one reason that I'm open to think about other ways. I'm a little bit uncertain about the potential of touching one piece of that framework without understanding all of the ramifications and all the different pieces. So I for one want to do a little bit more thinking about this issue.

MR. DURENBERGER: First, I am sorry I wasn't here for the second day of our November meeting at which did get into -- apparently you talked about the quality side of this issue. I agree with what you said about competition, haven't seen the kind of competition we really ought to have in the system in a long time.

But I particularly want to accent the values of specialization, having been part of the original decision to do DRGs but not do Part B at the same time, not knowing there would be implications to it. I've just watched over time the benefit of specialization. Hospitals have not been responsible for increased access or the increased quality that comes from specialization in this country. It's been physicians, and particularly surgeons, and a lot of other physicians, who have created opportunities, starting with the ophthalmologists, and we can now go into interventional this and that and non-invasive this an that and the other thing.

So I agree with what Nick and Jay have just said about whether it's within the context of, someplace in this context, the critical factor for beneficiaries is the quality of their care. The critical difference in making that happen is not the hospital. It's going to be the doctor because the doctor can influence the practice environment, the clinical environment, the hospital itself, all of the things that have to exist in a hospital. To the degree the doctors in a community like mine and others have not had that opportunity because all the leverage is in the

hospital, and all the leverage is in some other part of the hospital from where they're working, I would really hate to see any set of recommendations here that would take that incentive away from specialization. I'm talking principally about being involved with some of the fruits of performance, some advance control over how that performance is translated into the highest and best outcomes.

I'm not sure exactly how to get there but the bluntness of the second part of this recommendation, and even the way the first part gets to practically zero on everything including a whole lot of fairly creative, inventive parts of the health care system in cardio, cardiovascular, orthopedics and so forth, bothers me just a little to it. But I think the comments that Nick and Jay particularly made, and you have made, give me some assurance that when we try to deal with what's the law here that we will be able to find what my concern is that we are looking for.

MR. HACKBARTH: Thank you. Good work.

Next is payment adequacy for skilled nursing facilities.

MS. LINEHAN: Good afternoon. I'll discuss

payment adequacy and updating payments for the SNF sector. Sally will then discuss ways to improve Medicare's monitoring of quality.

In our March report we will be making an update recommendation for SNF services for fiscal year 2006. Current law calls for full market basket update to SNF rates in 2006 and that update is 2.9 percent. The Medicare program's skilled nursing facility payments were $14.7 billion in 2003.

I'll summarize some information I presented in October and then move on to some additional information on quality, access to capital, and margin information.

Medicare beneficiaries' use of SNF care increased between 1996 and 2002. The number of SNF episodes and the proportion of PPS discharges to a SNF both increased during this period. Some work by the OIG and MedPAC has found that access is generally good for patients seeking SNF care, but those that need certain services may experience delays. The OIG is currently doing work to look at current access for SNF services.

With respect to supply we see them from 2003 to 2004 the total number of SNFs participating in Medicare

remained almost unchanged, with the number of hospital-based SNFs declining 6 percent and the number of freestanding SNFs increasing by about 1 percent. Occupancy rates in nursing facilities have been on the declines since the 1990s.

Between 2001 and 2002 overall volume of SNF services increased, total payments, discharges, covered days, and average length of stay all increased. The average payment per day actually declined. This follows a 13 percent increase in average payment per day between 2000 and 2001.

Now I'm going to turn to quality. First I'll show a table we updated with a full year of data for 2001 and half a year of data for 2002. With the addition of these updated data you see that the shares of SNF patients rehospitalized within 30 days for all of these measures have increased.

For example, in 1999 3.7 percent of SNF patients were rehospitalized within 30 days with an electrolyte imbalance and in 2002 that share increased to 4 percent. These rates are adjusted for patients' expected rates of rehospitalization and calculated using all SNF stays, not a sample of stays. What's discouraging is that these show

declines during a period of time when all SNF payment add-ons were in place.

So taken together, the results I just showed you and other quality indicators I presented in October show a mixed picture of SNF quality with most measures trending down. Results from Chris Hogan's work on episode endpoints after 30 days showed a decrease in mortality but an increase in readmissions and a decrease in discharge home between 1996 and 2002. Trend data from 2002 to 2004 on the three short-stay patient quality indicators from CMS's Nursing Home Compare showed one measure improving, one with no change, and one that didn't have multiple years of data so we couldn't do a trend.

However, experts believe that these measures may be misleading, the Nursing Home Compare measures. Although here I've presented data on the few on quality indicators specific to short-stay SNF patients for purposes of assessing quality trends across industry, Sally will discuss ways to improve SNF-specific information to better monitor quality of SNF care in the future.

Access to capital for SNFs varies by nursing home control size and whether the facility is part of a larger

organization. Not-for-profit nursing homes had and continue to have limited access to capital, but large for-profit chains appear to have some improved financial performance over recent years. Several report capital expansions in 2003. An index of seven publicly-traded companies operating SNFs increased 12 percent between January and October 2004 while the S&P 500 decline 0.47 percent.

Providers currently regard Medicare payments as favorable but Medicare payments make up on average only about 12 percent of SNFs' payments, although more for some large for-profit chains. Potential refinements to the RUG-IIIs and the accompanying loss of remaining payment add-ons introduce uncertainties about the future of Medicare payments. The industry is especially concerned about these refinements because SNFs rely on Medicare payments to subsidize Medicaid payments.

In fiscal year 2003 Medicare margins for all freestanding SNFs, which are about 90 percent of all SNFs, averaged 11 percent. Hospital-based SNF margins were negative 87 percent in 2003. Based on 2003 cost report data we estimate that the 2005 aggregate Medicare margin for freestanding SNFs is 13 percent. Margins for rural

facilities, which are about one-third of total facilities, are higher than those for urban facilities.

We also find differences between facilities associated with one of the top chains. Margins for the 20 percent of facilities associated with a top-15 chain averaged about 16 percent while margins for other facilities averaged about 9 percent.

Consistent with our work in other sectors, we looked at SNF margins across multiple years for a consistent cohort of freestanding SNFs. We found that 5 percent of SNFs in the cohort had a negative margin in all four years. Of the remaining 95 percent of facilities, 60 percent had consistently positive margins and 35 percent had both positive and negative margins. The cohort of SNFs with a higher share of Medicare days were more likely to have consistently positive margins. We also found that three-quarters of SNFs that were part of a chain had positive margins in all four years while only 54 percent of the remaining SNFs had consistently positive margins.

SNFs' cost of providing care have changed dramatically since the implementation of the PPS in response to payment incentives. Before the PPS, Medicare payments

were based on facilities' incurred costs. Medicare imposed payment limits for routine services such as room and board but did not limit payments for capital and ancillary services, including therapy. The GAO and the OIG found that costs during this period were excessively high. For example, costs growth for ancillary services averaged 19 percent per year between 1992 and 1995 while the cost of routine services increased an average of 6 percent annually.

Under the PPS, SNFs have incentives to decrease their costs of providing each day of care. We analyzed cost growth for a cohort of freestanding SNFs with cost data in each year between 2000 and 2003. Preliminary results show that freestanding SNFs average annual per-day cost growth for Medicare beneficiaries was 3.6 percent in aggregate between 2000 and 2003. Market basket increase during this period generally tracked these cost growth numbers. Fifty percent of the cohort had average annual per-day cost growth between 0.2 and 7.9 percent. These findings are consistent with other research findings that SNFs have reduced their costs in response to the incentives inherent in the PPS.

This brings us to our draft recommendations, the first of which is that SNFs should be able to accommodate

cost changes in 2006 with the 13 percent Medicare margins they have in 2005. The 2005 margin was projected assuming that costs will grow by the full SNF market basket in 2004 and 2005. We recommend that the Congress eliminate the update for payment rates for SNF services for fiscal year 2006.

This recommendation would reduce spending relative to current law. With a Medicare margin of 13 percent we do not anticipate that this recommendation will have major implications for beneficiaries or the majority of providers.

Our second recommendation is one that we have made for the past three years. It's that the Congress immediately give the Secretary the authority to remove some or all of the 6 percent payment add-on currently applied to the 14 rehab RUG payment groups and reallocate some portion of the money to the non-rehab RUG groups to achieve a better balance of resources among all the RUG groups.

This reallocation of resources would be a redistribution of spending already in the system. We anticipate that this would redistribute spending among providers and improve access for beneficiaries.

DR. KAPLAN: In this chapter we also discussed the

need to improve Medicare's quality indicator specific to SNF patients. We exclusively focus on measuring quality for monitoring purposes and for MedPAC's assessment of payment adequacy. Our first look at these measures tells us that SNFs are not ready for pay for performance.

To better understand what information CMS currently collects to monitor SNF quality we interviewed representatives of CMS, researchers, clinicians, nursing home quality improvement organizations, the NQF, QIOs, and the SNF industry. We also reviewed the literature.

CMS collects three quality indicators specific to SNF patients. They are the percentage of patients with symptoms of delirium that represent a departure from usual functioning on a 14-day assessment, the percentage of patients at the 14-day assessment with moderate pain at least daily, or horrible excruciating pain at any frequency, and the percentage of patients who developed a pressure ulcer or had a pressure ulcer worsen between the 5-day and 14-day assessments. Forty-nine percent of SNF patients have a 14-day assessment.

The experts we interviewed believe the SNF-specific QIs are too limited. They believe that the QIs are

limited by the focus of the data used to construct the indicators, the validity and reliability of information, and the timing of data collection. In addition, they pointed out that the QIs do not focus on whether beneficiaries benefit from the care they receive in SNFs or whether patients achieve the goals for their care.

The source of the indicators, the minimum dataset, or MDS, was developed as a care plan for nursing home residents and is therefore focused on people receiving long-term care. In contrast, SNF patients generally are in the SNF less than 30 days and are expected to improve.

Current information on the validity and reliability of the three QIs is inconclusive. A validity study by a CMS contractor determined that the three SNF indicators were in the top class of validity and that indicators were very reliable. However, GAO has expressed concern about the representativeness of the validity study and also questioned the finding that the QIs are very reliable. In an earlier study of reliability the same contractor found high rates of error in the MDS items on an individual SNF basis.

The experts pointed out that the timing of the MDS

assessment is problematic for determining whether SNF patients improve over the course of their care. For example, 80 percent of SNF patients are in a RUG rehabilitation group, but we are unable to tell whether that rehab improves their functioning because ADLs are not measured at admission and discharge.

The experts suggested other quality indicators. Two of the three indicators they suggested are fairly available from existing administrative data, although not from the MDS. Experts unanimously recommended that rehospitalization be used as a measure of quality. Researchers frequently used this QI. For our payment adequacy assessment we have adopted potentially avoidable rehospitalization for five conditions, as Kathryn discussed, because these are risk adjusted and generally can be attributed to poor care in SNFs.

Most patients prefer to go home from a SNF rather than remain receiving long-term care in a nursing home. Experts recommend a discharge to the community as a measure of quality. Estimates of the share of SNF patients who do return to the community range from 42 percent to 70 percent depending on the research sample.

Finally, improvement in functional ability or ADLs were also recommended as a QI specific to SNFs. This QI would acquire measuring ADLs for all patients at admission and discharge.

The draft recommendation is on the screen. CMS should develop and use better SNF-specific quality indicators. Further, CMS should collect information on activities of daily living at admission and discharge to support the assessment of quality of care provided by these facilities.

The implications of this recommendation are no impact on Medicare spending, beneficiaries would benefit from QIs that assess whether they benefit from the care they receive, and SNFs would have a small increase in administrative burden but could have better information for quality improvement or marketing.

That includes our presentation.

MR. DURENBERGER: I gave up after the first year or trying to argue the 12 percent versus the 88 percent, but I do want to make an argument about expanding either the draft recommendation or certainly the content behind the draft recommendation.

Both Bill and I were recently selected to be on another commission called the National Commission for Quality Long-term Care, and one of the things that we know, not because we are on that commission, is that we have never quite been able as a nation or as a community, we have never been able to match up expectations that people have about long-term care or short-term care in nursing facilities with the capacity of people who are in the professions to deliver. So we have opted for a quality system that is not the kind of quality system that any of us would want, and I think you've both pointed that out to us. It is largely a regulated system, national regulations implemented at the state level. A lot of professionals instead of being in the care business are busy filling out forms and reporting on this, that and the other thing and calling me every time my mom falls out of bed or whatever the case may be.

So one of the challenges in matching expectations and capacity within the system -- I guess the other point I want to make is that to the extent that there is an implication in any of this that there's an industry out there that's simply making enough money and not caring about quality, that is not the case, because largely this

commission at the National Quality Forum is being financed by the industry because they're so anxious to get the answers to the question that we are raising here.

But no matter how this comes about after we go through some process of matching up expectations, capacity, we are going to get to financing, which is where I was two years ago when I first started being concerned about this, and that is, you get what you pay for. Unless you figure out how you are going to pay for quality, and what that means -- you've got to determine what quality is in this area -- we're saddled with a system which is 12 percent Medicare so we just look at that little piece of it, then over here is Medicaid and we all know what's happening to the Medicaid, and then there's the poor beneficiaries out there, or the poor families out there paying for all the rest of it, and nobody is in charge.

So I just have these fairly strong feelings that I'm not expressing very well, that I would like to see, even though I know we have to focus on the 12 and I know we're probably going to end up with this kind of recommendation, I think we ought to elaborate on that on behalf of the population of Medicare-eligible people whose needs are not

being served by the current system. All the dual eligibles and everybody else I talked about earlier, their needs are not being met by a system that is fractionated between the Medicare, the Medicaid, and does not deal effectively with what we would like to see dealt with here, which is what is quality and how should quality be paid for, whether it's in the Medicare system, the Medicaid system, or in private pay.

So I would hope I could persuade us to structure some language that would expand this recommendation as it relates to quality so that it is more focused on all of these people that are out there in the system rather than just on the Medicare reimbursement.

MS. RAPHAEL: I'm just wondering if we can take that last recommendation, which I think is very important -- I mean, the second recommendation we have made before. It is a repeat performance. I guess in January there's supposed to be something coming out.

But the third recommendation seems a little soft to me given what we have seen here, which is that the trends don't seem to be very promising. Most people going into a nursing home is a very difficult event. Even if you are there for 15 days or 20 days, it is one of the most

important health events you're going to experience. So seems to me that we have to do more and we have to do this with greater urgency than we are conveying here.

I don't know whether we should separate out the admission and discharge, whether that's easier to do or harder to do, whether it's easier to fold in the potentially avoidable rehospitalizations, and tracking discharge to community, and functional improvements. But I just feel that we need to get going in this area and we shouldn't be here next year again saying, we really can't do anything in this area because we haven't made any progress.

MR. HACKBARTH: I agree about expressing a sense of urgency. Ordinarily we do that in the text as opposed to putting exclamation points in the recommendation.

[Laughter.]

DR. MILSTEIN: My comments are along the line of Carol's. I think that particularly with respect to the two quality measures based on administrative data, relative to the gain if we were to have this in place, this doesn't seem to me terribly challenging to construct. Maybe short of an exclamation point, at least a recommended date by which these better measures are in place, including the initiation

of the collection of the functional status measurement at the time of admission and discharge. The inputs for these are already available and I personally would say, not to exceed a year from the date at which we make the recommendation.

MR. HACKBARTH: Any others?

Thank you.

Next is home health.

MS. CHENG: Last month I presented the first half of our payment adequacy analysis for this factor and I'd like to acknowledge the work of Chad and Sarah on our staff for a lot of the work that they put into that analysis. Today I will bring you the second half of this analysis, along with a draft recommendation for your reaction.

To get us oriented, we're discussing the update for calendar year 2006. In the past we have discussed home health updates for fiscal years, but that was before the MMA changed the update cycle for this sector from a fiscal year one to a calendar year one. Under the current law this update is market basket minus 0.8.

Medicare spent about $10 billion on home health services in 2003, and the Office of the Actuary projects

that home health spending will continue to grow at an average annual rate of 4.7 percent over the next 10 years. Using a different set of assumptions, especially regarding the growth of private plans versus traditional fee-for-service, the Congressional Budget Office estimates an annual growth rate of 11 percent over the same period.

Last month we discussed three factors that suggest current payments for home health are adequate. Beneficiaries' access to care is good although some beneficiaries continue to experience some access problems. The quality of care as measured by the Home Care Compare dataset has improved slightly, and we have noted that home health agencies are now entering the program at a greater rate than they were exiting it.

The new pieces of the adequacy analysis that I will bring to you today include trends in the volume of services. What we note this year is that trends that we have measured in the past are continuing. The number of episodes has continued to increase between 5 percent and 10 percent in 2003, depending on how you treat episodes that lap over the beginning or end of a calendar year.

But at the same that the number of episodes has

increased, the number of visits or minutes within an episode has continued to decrease. The average number of minutes per episode fell 8 percent from 2002 to 2003. The average number of visits per episode fell from 18.8 in 2002 to 17 in 2003.

The other part of our adequacy analysis that I will present to you today is our consideration of the relationship of Medicare's payments to costs. We do this looking at the freestanding home health agencies.

We are projecting a decrease in the margins for home health agencies from their current level of 13.6 in 2003 12.1 percent for all agencies in the aggregate. Private proprietary agencies continue to have the highest margins while voluntary fall in the middle and government agencies have lower margins.

In the past rural agencies had slightly higher margins than their urban counterparts. That was due in large part to rural add-on payments. However, you will see in 2003 and again in 2005 that relationship has changed. Rural agencies have a margin of 10.6 while urban agencies have 14.1. The lack of any rural add-on for a year between 2000 and 2005 and the sunset of the current rural add-on

which we pull into our 2005 projection are both reflected in that 2005 margin.

Hospital-based home health agencies reported margins of negative 4.6 in 2003.

As we've seen in years past, the financial performance of individual agencies vary a great deal around this average aggregate margin. About 20 percent of that home health agencies had negative margins in 2003. In contrast, on the other end of that spectrum 25 percent of home health agencies had margins above 25 percent.

This year we also took a somewhat different look at margins and we looked at accumulation of margins rather than just a single year at a time. The PPS for home health has been in place for about three years so we have a three-year cumulative margin for home health agencies. When we look back over that entire period we find that most agencies have accumulated large positive margins. Consistent with our single-year measurement, private agencies had higher margins than voluntary or government ones, and urban fared better than agencies with mixed caseloads, which is to say some of their patients were in urban areas and others were in rural areas, and urban fared better than those with

entirely rural caseloads.

When we look at this three-year cumulative margin, 80 percent of all agencies had a positive three-year margin and 20 percent had negative ones.

We also took an opportunity this year to look at the cost per episode for a three-year cohort. Between 2001 and 2003 for the agencies that we could include in all three of those years, aggregate cost per episode fell by 1 percent. This aggregate decrease is the combined effect of some agencies' large cost reductions and other agencies' small increases in costs. Large agencies in terms of the volume of services that they provide had costs that fell 6 percent while the smallest agencies in terms of volume costs grew 4 percent. We also observed that rural agencies' costs fell 13 percent.

The decreases in the visits and the number of minutes per episode are probably the chief drivers behind the decrease in costs that we observe over this period. Also, some agencies report that adopting such care improvement technologies like wound dressings, or technologies such as point-of-care computers and telehealth have also allowed them to improve nurse productivity and

reduce their costs. Rural agencies have also reported to us anecdotally that over this time period they've been rationalizing the travel patterns of their nurses which has allowed them to reduce some of their costs.

In the second phase of our framework, having considered the adequacy of payments in the current year, we also look ahead to see what changes we anticipate in the coming year. For home health we note that wage pressures from the nursing shortage and also successfully union negotiations will increase the prices of labor in this very labor-dependent sector. We also believe that the slow diffusion of science and technology in this sector will continue. These influences will tend to offset the cost reductions that we've observed so those cost reductions may not continue as we look forward.

The market basket projection for the increase in prices for home health is 3.1 percent for 2005. A combination of generally positive indicators of access and quality along with more than adequate current margin and slow cost growth suggest that agencies should be able to accommodate cost increases over the coming year without an increase in base payments.

As your draft of this home health chapter notes, some of the research that we presented at our last meeting regarded the variability of services in this sector, raises questions about the structure of the payment system as well as the level of home health payments. We will pursue those questions about the structure of payment in at least two ways over the coming year. We have a mandated congressional report in which we'll be looking at the relationship between case mix and financial performance, and also we are going to take a look at the PPS and alternatives to prospective payment for this sector perhaps as a chapter in our June report.

The draft recommendation that we are bringing to you for your consideration is that the Congress should eliminate the update to payment rates for home health care services for calendar year 2006.

The spending implication would be a decrease in spending over the baseline. But because of their current aggregate margins and our belief of changes in the coming year we find no major implications for beneficiaries or for providers.

With that I'd like to open it up to your input and

questions.

MS. DePARLE: Like some others on the Commission I've met with some home care agencies recently and they had data and numbers on margins that was very different from what we are looking at. They say that it's from CMS and they have questioned me about why do we use such different data, and I'm going to lob it over to you because I don't know the answer. They say they have data that's from cost reports that doesn't show these kinds of margins.

MS. CHENG: I haven't had a chance to sit down and go specification by specification over my model and their model so I can't speak to the specifics. I know that two areas that cause our margins to differ, sometimes a great deal, are the inclusion of hospital-based home health agencies in the aggregate.

The second is whether or not you're looking at this sector on an aggregate basis or a facility-weighted basis. It makes a big difference in this sector because some agencies have caseloads of over 5,000 Medicare beneficiaries so when we revenue weight we are looking at what the experience of most of our beneficiaries are when we look at our aggregate. If you facility weight it you're

giving it equal weight to the performance of some of the agencies on the other end of the spectrum, and the smallest agencies in this sector see fewer than 100 patients a year. But if you facility weight it you are giving equal weight to that experience as you are to the experience of 5,000 beneficiaries at a larger agency.

MS. DePARLE: So the CMS data you believe includes hospital-based home health agencies and our data does not?

MR. PETTENGILL: Our data does not include the hospital-based.

DR. MILLER: They say themselves that they have some skepticism about the hospital-based data. That was actually in a couple of newsletters that they put out. Correct me if I'm wrong, when they do the facility-weighted data -- and I'm remembering this from previous years so I could be wrong on what's currently going on -- they were still getting positive margins, were they not?

MS. CHENG: I don't know what their most recent estimate looks like.

DR. MILLER: But in the previous year I thought that they were, and they weren't small as I recall.

MS. CHENG: They were smaller than the margins --

DR. MILLER: They're smaller than ours, no question. But I didn't think they were negative.

MS. CHENG: I think that's right.

MS. DePARLE: From what they told me they're not negative but they're much smaller, single digit numbers than what we're seeing the last couple years.

DR. MILLER: The way I remember it is numbers like half of what ours were when you go to a facility-weighted approach.

MR. HACKBARTH: It seems to me that revenue-weighted, the way we do it, is the right way to do it. This is the way we do it across all industries and not just home health. But in particular when you are talking about these tiny home health agencies that may not even be anywhere near efficient units, I don't think you want your payment policy driven by lots of very small units. You want a sense of overall how your payments are comparing to costs and that requires revenue weighting as opposed to facility or provider weighting.

Anything else on that, Nancy-Ann?

MS. DePARLE: We had a long discussion -- I'm looking at Sheila because I think I was sitting by here the

last time. We had a long discussion sometime in the last six or eight months about this benefit and how much it had changed, and our questions about how much of that was intentional, and whether the frailest beneficiaries were still being served in the way that we wanted them to be.

So I'm still mulling those things, and I guess in my discussions with these home health agencies they have made the case that their margins are much smaller than the numbers we're looking at, and I hear our answer to that. But secondly, that something like the rural add-on that they've gotten has been critical to some of their agencies in being able to continue serving beneficiaries. I don't know, Sharon, if you've had a chance to look at that, the rural add-on in particular, and whether we think that's legitimate.

MS. CHENG: We did continue to look at agencies by caseload, and when we measured their margins in the aggregate the rurals are now lower than the urban. Before the add-on sometimes made them actually flip above the urban. But when we projected the margins by type the rural margin was still positive.

MR. HACKBARTH: Remind me where we are. Was it

last year that we recommended the 5 percent add-on be extended? Was that rural home health?

MS. CHENG: Two years ago.

MS. DePARLE: One of the most optimistic things I saw from the home health agencies that I talked to was the way in which they are being able to use the OASIS data that they are collecting now to really manage the care of their patients and to have a much better sense of how the patients are progressing, and how they are doing. That, as we look at all the bulk of the work that we have been doing today on quality, is a very hopeful sign.

MR. HACKBARTH: Let me just engage in some MedPAC speak here for a second. It's our custom to the distinguish between the aggregate level of payment and the distribution of payment. Based on these data, based on many years of discussion of this, I don't think the issues here are so much about the aggregate level of money flowing into the home health industry from Medicare but rather the distribution of those dollars and whether we are getting the dollars to the right places and they accurately track with the cost of treating different types of patients. We included a passage last year as I recall in our report

identifying that as a concern.

In addition to that, we received a mandate in MMA to study the case mix issue and the report on that is due when?

MS. CHENG: November 2005.

MR. HACKBARTH: So that's a piece of work that I think is critically important and I think can start to give us some new thoughts here. So I continue to feel confident that this is the right update recommendation. I don't want people to construe that as I think everything is hunky-dory in the home health world. I don't believe that to be the case.

MS. RAPHAEL: I think the study that we have to do is important, I just have one question. It is my view that, we looked at the DRG system today 21 years after its inception and we saw what had happened. I believe three years after the home care PPS some of the same trends are already apparent and that we are not really paying for the true cost of care. There are certain areas where we are rewarding what Ralph would call the art of selection rather than the true resource consumption.

So one of my concerns is whether by looking at the

case mix adjuster whether we are really going to get at that broader issue which I think is the same issue but in a different sector.

MS. CHENG: I have been trying to interpret our request from Congress pretty broadly. What I hope to be able to do with this report is to determine whether or not case mix is related to financial performance, and in so doing tease case mix out from some of the other things that we will be able to learn about the patients that agencies take and their efficiencies. So I hope to use the full set of OASIS information, so not only will we be able to look at the pieces that go into determining the case mix, but we could also pull in things like comorbidities, is there a caregiver at home, what is the Medicaid caseload?

So what I hope to be able to do is put all those pieces together so I will be able to say, case mix might be part of it but let's find out, if that is not the whole story what the story is. So I'm trying to take that pretty broadly.

DR. MILLER: Even before we got the mandate, as part of our agenda Sharon is going to be looking at pieces of the program, and you'll remember either the last meeting

or the meeting before that, she went through the outlier policy. So we are trying to zero on each of the pieces of the program to begin to do this. Whether we have this mandate or not and whether we house all of what we find in the mandated report or not this is an agenda for Sharon.

MR. MULLER: I will just second Carol's concern. I suspect as we look into this we will see some real case mix weight issues, at least that's been my experience in this field. I think getting those weights right, for the reasons that Carol mentioned, is important. So we'll know a lot more of this by November. I think from your answer to Carol's comment you have the flexibility to look fairly broadly at this and some of the severity issues we were looking at in the DRG system you'll look at as well.

MS. CHENG: We don't have a nifty APRDRG to pull off the shelf but we will be able, I hope, to include in our models some of the other things that OASIS tells us about the patients and some important things like comorbidities, cognitive impairment and --

MR. MULLER: I think you'll see some of these rehab/non-rehab issues that we discussed in the past coming through quite clearly once you look at this.

DR. WAKEFIELD: A couple comments. The rural agency margin concerns me a bit because of the downward trajectory and also in light of our discussion this morning in our update discussion about what might be going on in the hospital side of the equation, knowing that we've now moved from a 10 percent rural add-on that expired last year down to a 5 percent add-on. I would say that is obviously contributing to the direction that this margin is going. The recommendation concerns me a bit about no update at all given that downward trajectory for rural home health.

Part of what's always been a nagging concern for me in the back of my mind is how we define access here. We say pretty strongly that access is solid given the way we define it. And the way we define it is using zip codes, and whether or not a Medicare beneficiary has been serviced within that zip code in the previous 12 months. I think we have to keep in mind that some zip codes in the western part of the United States are larger than some states in the northeast, or they're awfully big. If that's an overstatement it's probably not too much of an overstatement.

What I hear from rural health care agencies is

they are looking rapidly at 25 mile radii. We would never pick that up, that they've pulled back, if they are servicing a 25-mile radius in terms of what happens to the other hundreds of miles or thousands of miles. So I'm always a little bit nervous about access for Medicare beneficiaries. So those are my concerns about the direction that the margins are moving on home health agencies in rural areas and that makes me nervous about the recommendation as it stands, no update across-the-board.

DR. STOWERS: Just to build on what Mary is saying, I totally agree with all that is wrong with the system and the rehab side versus acute care, chronically ill patients and this group is more apt to be taking care of those ones that we're most concerned about in the system. I've never seen it done but I'm just wondering while we're waiting on the study if in the recommendation it could be holding level except adding the market basket to level things out in the meantime for the rural in the recommendation. I don't know if we can split that or not, or whether it would be easier to add the 5 percent back in.

MR. HACKBARTH: I think that is what you would want to do as opposed to having a different market basket

that then gets in the base and in perpetuity you've got a different level. A temporary add-on is I think the preferable way of dealing with what might be short-term problems.

DR. STOWERS: But I think we've got some pretty clear numbers here that we probably did need the 10 percent that we had before and maybe the Commission needs to come out and put that back where it was in the meantime.

DR. NELSON: I think we ought to build some caveats around our interpretation of the quality information. I think improvement at walking around, improvement in bathing, patients who are confused less often and so forth, those kinds of measures are helpful for the agency to internally use and lead to quality improvement by telling them where to put their emphasis. That may help some.

It is of less value in publicly reporting in leading patients to be able to select a home agency because they all subjective, they all self-reported. There isn't anything quantifiable in here. They are of virtually no value in making an assumption about whether the quality of care is getting better or worse, just because they are all

subjective.

So I think a sentence in there that's says that it's pretty hard to make quality conclusions based on the current measures doesn't make us look naive.

MS. CHENG: I will certainly try to capture your concern, I just wanted to maybe understand it a little better. When we measure patient outcomes in this setting we are using the patient assessment tool. All lot of the fields that we using -- not for all of the OBQIs but for some of them -- are also payment fields. So we have got FIs. We have got some level of audit that do look at this. And the home health agencies or held to the same standard as anyone else who submits a claim, when you submit the evidence that supports that claim there's a standard that has to be upheld. A lot of these measures are based on that.

CMS has also done a fair bit of testing on the validity and the reliability of these measures and I can certainly bring that back to you. There are differences in the reliability and the validity of measures within the whole set of 41, but for many of these the science suggests that they are fairly reliable and valid measures. So I

would like to capture your concern but I need to understand it a little but.

DR. NELSON: Maybe I need to be corrected, but improvement of walking around, for example, is entirely in the eyes of the beholder on whatever day they want to say it. Improvement of bathing, or patients have less pain. You ask a patient, are you having very much pain? All I'm saying is that it may be that that is accepted and has been validated and that is what the field is using, and I think if they are using it for their internal purposes that is great. But if I am trying to select a home health agency that is best for my family, they don't tell me very much, because the variations are very small -- I have looked it up -- from agency to agency and it depends -- they are entirely based on the perception of the person making the observation in the home and that person obviously has a bias if it's being used in the marketing sense.

DR. MILLER: If there's a bias, these are the same measures that are used for payment purposes as well. You go through and you make the assessment on OASIS. If there's a bias here then the bias is towards saying that they're doing less well in order to up the category that you are in. I

think some of what you're picking up on here is that we are looking -- these are the same metrics that are used for the payment purposes. We do believe that there's probably some issues around the reliability, because there are issues that are recognized, there's guidance, and in a sense the same kinds of issues that surround what Sharon was saying, any submission of a claim apply here.

The way I could get to your point is I can see how, particularly if there are small variations in this, how as a public reporting device there's probably an issue there and I think we could probably make that point. But if your point is that you think that this metric doesn't work at all, I think we have larger issues because we have been talking about this as our payment classification system. This is how patients are classified and this is one of the things that we're thinking about, part of it, for pay-for-performance. So I want to make sure we understand the depth of your comment here.

DR. NELSON: It probably isn't productive for me to push it any more. I guess I'm thinking of performance measures in a much more rigorous application.

DR. SCANLON: A question that might shed some

light on this, and that's the issue of what scale is in OASIS, and I can't remember. But in many of the activities of daily living scales what we're talking about is questions like, do you require the assistance of a human being, do you require the assistance of equipment, or do you walk unaided. It's not whether when you're walking are you walking, stronger, faster or anything like that. It's much more discrete and therefore much more objective, even though sometimes they will ask questions about how much difficulty you have. But I guess I'm not sure what's in the OASIS but it's potentially comes across a little stronger than what it may seem like when it says improvement in walking.

DR. NELSON: That's helpful.

DR. REISCHAUER: Ray and Mary are worried about whether 6 percent represents an adequate margin, and in some other provider groups we'd be happy with 6 percent. Surely there is an inequity when one group has 6 percent and the other group has 10 or 13 or something like that.

But I was wondering if we could zero in on some of the other dimensions we look for urban-rural and not just margins. One of them would be quality. Is there any way to see what the trend in quality has been? Overall you say we

have had some small uptick in quality. But is that true if you cut it urban-rural?

The main issue which Mary focuses on, appropriately I think, is access. This is very hard because the incidence of home health use varies all over the lot, state by state or region of the country by region of the country. I was wondering if you looked at similar geographic areas, North Dakota, but you looked at the trends in geographic areas and saw if the percent of, or the number of services per 100,000 Medicare beneficiaries is trending the same way in those rural areas as it is in the urban areas. And your anecdotal evidence that there are home health agencies there, but some of them are shrinking their service areas, or it's just less easy for people to access their services would show up in something like that, whereas it doesn't show up in the measure that you are using for access.

MS. CHENG: There's not a lot of time between and January but I can --

DR. REISCHAUER: This could be for next year. I think this discussion, if I remember correctly, has occurred every year I have been on the Commission.

MS. CHENG: What I can also bring back, the OIG took a look at access and they compared urban access and rural access. We were hoping to have a refreshed version of that report for this sector in this cycle, and they have told us that they're not going to be able to have final results in time for us to look at it. But I can ping them and see if there's any kind of initial result that they would be willing to share, because they have undertaken that effort again, to really get into urban-rural access differences and they have been interviewing providers, area agency on aging, and discharge planners to get on-the-ground look at that.

DR. WAKEFIELD: Just on the quality issue, a little bit of the feedback that I've gotten from the part of the field that I pay a little bit more attention to is that some of the quality improvements are not necessarily due, some would say, due to actual improvements in the patient, but rather from some of the agencies themselves better documentation or variability in documentation. That has been in the back of my mind as well as I read the quality piece of this, how much is capturing what is really going on and how much is just a change in staff assessment

techniques? I would defer to Carol about that but I can tell you from the agencies they would attribute some of the bumps up or leveling to changes in how people are coding information.

On the margins, did you give us a margin in home health based out of hospitals? Did you give us a Medicare margin on that, when you went through your narrative but not on the slides, because I thought I heard something related to hospital-based home health margins.

MS. CHENG: We looked at the margins reported by hospital-based home health agencies and in 2003 that aggregate is negative 4.6.

DR. WAKEFIELD: When I was speaking earlier I was really speaking to freestanding seeing a fall down to six as you pointed out, but also to the outpatient, because I didn't see it up here but I thought I had heard you say that.

MR. HACKBARTH: I would think that the cost allocation issues get especially important when you're talking about small, hospital-based home health agencies. I don't know exactly how the cost would be allocated, but relatively small allocations of cost could have a big impact

on the margin for a small agency. Whether that's reality, that ought to be recognized in payment.

DR. STOWERS: I just wanted to answer Bob. I may not have said that very well. I really was talking access, because if we have had a recent change in law that dropped the reimbursement in the rural areas by 5 percent, I don't see there's any way that that rural agency that is taking care of more chronically ill medical patients compared to the urban that probably has a higher number of rehab, which we know there is a discrepancy, could be offering the same services at 6.1 -- although I know a lot of areas of medicine would like to have a 6.1 -- compared to other agencies that have a 13.2 percent.

If we talk equal access to care for Medicare beneficiaries in home health, I don't see how two agencies standing side by side could pull off equal -- maybe it takes a long-term study of true access and quality to see that it does translate. But intuitively, you would think that an agency that had its profit margins dropping in half while the other agencies are maintaining essentially the same profit margin would have to make some adjustment in the services that they were providing. That is why I was saying

it looks like to me we were where we belonged before the 10 percent.

DR. REISCHAUER: Notwithstanding my initial joke, I was actually trying to find some metric to support your case. I was trying to be a friend.

MR. HACKBARTH: We are to the final agenda item of the day, dialysis services.

MS. RAY: Good afternoon. In the session we will continue our discussion that we started at the October meeting about the adequacy of Medicare's payment for outpatient dialysis services. I'd like to first take you through a quick history of dialysis payment policy pre-MMA and post-MMA. I want to do so because of the significant changes that have been mandated by the MMA and that will begin on January 1, 2005.

I think from my perspective there have been three major developments in outpatient dialysis payment policy. The first is when the composite rate was implemented in 1983. Congress mandated the implementation of a prospective payment rate which is called the composite rate, and the payment rate was designed to include all nursing services, supplies, equipment, and drugs associated with a single

dialysis session. The payment rate, the composite rate was based on 1977 through 1979 cost reports.

The second major development from my perspective was the approval of erythropoietin in 1989. This was the first major dialysis injectable drug. Since then payments for these separately injectable drugs have increased relative to composite payment. MedPAC data goes back to 1996. There we saw the split at 70 percent composite rate, 30 percent injectable drugs. Now looking at 2002-2003 data we see the split at about 60/40, 60 percent composite rate, 40 percent injectable drugs.

So this table summarizes the pre-MMA payment for outpatient dialysis services in 2004. You'll note a couple of items here. First, there is a $4 difference between freestanding and hospital-based facilities. This $4 difference stems from the Congress mandating HCFA to develop one rate for hospital-based facilities and another rate for freestanding. Using the 1977 cost report data they found a $4 difference which they attributed to overhead, not to differences in patient case mix or complexity.

The other point I would like you to take home here is the payment for separately billable injectable drugs.

Erythropoietin payment is mandated during this pre-MMA period by the Congress so both freestanding and hospital-based facilities are paid $10 per 1,000 units. Note the difference for other separately billable drugs, 95 percent AWP for freestanding facilities. Hospital-based, by contrast, facilities get reasonable cost.

So let's turn now to the third major development in outpatient dialysis payment policy and that is the passage of the MMA and the fact that it will begin to be implemented by CMS beginning on January 1, 2005. There are three big changes that will start in 2005. The first is the add-on adjustment to the composite rate. The second is case mix adjustment, and the third is paying for most injectable drugs, but not all, based on the average acquisition cost.

So let's start with the add-on adjustment, what is it? The add-on adjustment represents the profit margin associated with all separately billable injectable drugs furnished by freestanding facilities, and erythropoietin furnished by hospital-based facilities. So when you take this pool of money, this profit margin, and you distribute it equally across all treatments it calculates up to an add-on adjustment of 8.7 percent of the composite rate. So both

freestanding and hospital-based facilities will receive this 8.7 percent add-on adjustment to their composite rate beginning on January 1.

In case my words aren't clear, here is a graphic description of the composite rate. Here you see the $4 difference. This is in 2005. And you see the 8.7 percent application of the add-on adjustment.

So this table summarizes all of the changes that will occur beginning on January 1. The composite rate will be increased by 1.6 percent, so you see now the payment rate will be $128 for freestanding, the base rate, versus $132 for hospital-based. That reflects the 1.6 percent update. The add-on adjustment is the same for both facility types. Case next adjustment is the same. I want to note that the case mix adjustment, payment will be adjusted using six age groups and two body mass measures. Height and weight is going to be used to calculate the BMI. Beginning on January 1, facilities will be required when they submit a dialysis bill to also report patient's height and weight.

Now you will note the continued difference in payment for injectable drugs. For both facility types erythropoietin will be paid on average acquisition cost.

Where does this average acquisition cost data come from? From a report that was mandated by the Congress and submitted by the IG during this year. They looked at the average acquisition cost for erythropoietin in the 10 leading dialysis injectable drugs for freestanding facilities. They reported 2003 data for these injectable drugs.

However, you will also note that other injectable drugs other than erythropoietin, hospital-based facilities will continue post-MMA to be paid reasonable cost. For a very small minority of drugs currently, freestanding facilities will be paid average sales price plus 6 percent.

DR. NELSON: How does the average acquisition cost for Epo now compare with the previous payment?

MS. RAY: I don't have the exact number. Pre-MMA Epo was $10 per 1,000 units. Post MMA it's about $9.70-something. But facilities will also be paid separately post-MMA 50 cents per syringe used for Epo. So it actually comes out to be a little bit more post-MMA for Epo.

MedPAC has repeatedly recommended expanding the payment bundle and modernizing the outpatient dialysis payment system. We set forth a series of recommendations in

our 2001 report. I think the MMA does take some small steps towards our recommendations, most notably by implementing the case mix adjustment. But the MMA has created some problems and the Commission might want to think about identifying these issues in the March report and continuing to work on them in the spring.

There are four issues that we raised in your briefing materials. The first relates to the different composite rate payments between facility types. Now that payment is case mix adjusted it may not be necessary to continue this payment differential between freestanding and hospital-based facilities.

The second issue concerns the add-on adjustment. This methodology may not be the most appropriate way to pay for dialysis services. As noted by MedPAC and other researchers, the current drug payment policy promotes the less than efficient use of drugs by certain providers. The add-on adjustment continues to base payment on a less than efficient policy.

The third issue relates to the post-MMA method of continuing to pay injectable drugs using three different methods. At issue here is potentially just using one

method, some sort of average acquisition cost that the MMA calls for, but using the same method to pay for all drugs across freestanding and hospital-based facilities.

The fourth issue concerns the comprehensiveness of the average acquisition cost data from the IG. It does not include all dialysis injectable drugs and the long-term sustainability of it. It will be updated each year by the PPI, but as time goes on it may not accurately represent the acquisition cost if negotiating practices change between providers and manufacturers.

The other issue that we raised in your briefing materials concerned monitoring and improving quality. Here I just want to be very brief and note our pay-for-performance recommendation that we made in last year's March report.

Your briefing materials also laid out MedPAC's longer-term workplans concerning continuing to monitor beneficiaries' access to care, particularly with the changes mandated by the MMA, and looking at ways the continue to improve outpatient dialysis payment policy. I would be happy to take any questions you may have about that.

So let's move on to looking at payment adequacy.

Recall at the October meeting we discussed the first four measures that are highlighted in yellow. We did not find major problems with beneficiaries' access to care. We will follow up on one finding, that closures may be disproportionately occurring in areas where a higher proportion of the population is African-American. Dialysis quality is continuing to improve for some measures, and both capacity and volume of services continue to increase.

So let's move on now to the two measures we have not yet discussed and that is access to capital, and Medicare payments and costs in 2005.

Concerning access to capital, indicators suggest that providers have adequate access to capital. There was an announcement just this week that the third largest national dialysis chain will be purchasing the second largest chain, and according to the public announcement they will be relying on bond and bank debt to do so. This suggests that the capital markets are confident about the dialysis sector.

However, there are three developments that could affect long-term access to capital in the future which we will continue to monitor. Two relate to the changes in

Medicare policy, the MMA and the Epo monitoring policy, and the third relates to a subpoena that was issued to three of the national chains related to their lab testing and use of certain injectable drugs.

I'd like to now discuss Medicare's payments and costs. The first thing we looked at here is the appropriateness of cost, and we looked at it two ways. The first way we looked at changes in cost per hemodialysis treatment between 1997 and 2003. There are a series of points I'd like you to consider.

There seems to be three distinct periods here. Costs grew modestly between 1997 and 2000 at about 2 percent per year. Let me interrupt myself and say that this is for freestanding dialysis facilities only. So we have modest cost growth in the late 1990s. Like some of the other institutional providers, costs increased substantially between 2000 and 2002, and costs declined by 1.5 percent between 2002 and 2003. This is based using cost reports for each of these time periods. There were facilities that were open and had cost report data in each of these years.

We're going to follow up on this decline in cost per treatment. What we do know so far is when you look at

the change in cost by category, that is capital, labor, other direct, and general administrative, you do see differences here. General administrative costs increased the most between 1997 and 2003, by about 5 percent per year. By contrast, other direct costs decreased by about 1.8 percent per year. So in January we will report back to you on the changes in cost growth per category within each of the years.

I'd also like to point out here that, as you discussed in some of your earliest sessions, we are looking at averages here. Cost growth varies. Overall we have an average annual cost of about 2.2 percent, but per-treatment costs for facilities in the 25th percentile of costs grew at about 0.3 percent. By contrast, facilities in the 75th quartile, costs grew at 4 percent.

Moving into the other aspect of how we look at the appropriateness of cost, we looked at the relationship between the costs that providers report on their cost report and what is ultimately found to be Medicare allowable. The industry has criticized MedPAC in the past for continuing to use an audit factor based on 1996 data. So we analyzed the 2001 cost report. Keep in mind that the BBA has a

requirement that the Secretary audit dialysis facilities' cost reports.

We still find a difference between reported and allowable costs for those facilities that were audited. What we did is we looked at the cost per treatment using this year's 2001 cost report and compared it to last year's 2001 cost report. So we will continue to apply an audit factor, but in a more defined fine manner than we have done in the past. Specifically we will apply it to those facilities that you do not have settled cost reports.

So this leads us now to the Medicare margin for freestanding facilities estimated for 2003 and projected for 2005. Here you are looking at the aggregate Medicare margin composed of payments and costs for both composite rate services and the separately billable drugs. I know I'm repeating myself but this is 2003 cost report data merged with 2003 claims submitted by freestanding facilities. These margins do reflect the audit factor.

Next up in our framework is to consider how providers' costs will change in 2006, the coming year. I want to start with the growth in input prices between 2005 and 2006. We have adopted the CMS market basket and they

project prices will increase by 2.8 percent.

Next let's consider MedPAC's policy goal of encouraging provider efficiency. In past year's we have applied the productivity goal in our recommendation and I think commissioners should consider several points for continuing to do so for 2006. The cost growth between 1997 and 2003 is less than the cost growth as predicted by the CMS market basket during this time period. The cost per treatment has declined between 2002 and 2003. And our adequacy measures, access, capacity quality, and access to capital are strong.

The other factor that could potentially affect providers' costs is new scientific developments. As we have concluded in the past, these are mainly associated with separately billable drugs and in 2005 they will continue to be paid for separately.

So this leads us to a draft recommendation for you to discuss. The spending implications, it will increase spending over the baseline. In terms of beneficiary and provider implications, no major implications.

MS. DePARLE: Nancy, thank you for a very strongly done job here. Thank you for updating the audit factor,

because I think I'm one of the ones who has raised that with you before, that it was out of date.

There were some things that were highlighted a little bit more in the text of the document than you were able to in this short presentation, and I guess I would say that I would think we might want to consider recommendations around some of them. The $4 difference between the freestanding facilities and the hospital-based facilities in composite rate really sounds like an historic anomaly. I am not sure why that needs to continue. That is something that highlighted in the text.

The issue around the add-on adjustment and how it is spread both between the freestanding facilities and the hospital-based facilities in a way that results in the hospital-based facilities getting more of the adjustment than one might argue the formula should entitle them to. This is from the rule that was done this summer. We talked about that in here and I thought we were against that, or I thought we didn't think it was fair. So I for one think there should be a recommendation around that.

The finally, you have highlighted, for me anyway -- I am not sure I understand a compelling reason where there

are different ways of paying for drugs, injectable drugs, among the different settings. I think we should at least consider whether there is something we could say about that.

DR. REISCHAUER: As information that would inform my support or lack thereof for Nancy-Ann's proposal with respect to eliminating the hospital differential, a pot of money was created by looking at the excess profit from freestanding and from hospitals, lumping it together, dividing it by total composite spending, and coming up with one percentage and then applying it back to the differential composite rates.

I guess my question would be, if you just looked at the money that was being taken away from hospitals, what percent of their total composite spending was that? And if I looked at the portion that was taken away from the freestanding related to their composite -- because if we're taking away unequal amounts or percentages, why would we be adding them back equally, and it might give a justification for eliminating that. Do you understand what I'm saying?

DR. MILLER: Some of the reason we didn't rush to recommendations here, although we think there's a whole set of issues that have been implicated here -- and I'm going to

say something that might not be as complicated as that hopefully -- but he's on to something here.

The reason that we did not rush to recommendations here is this gets really complicated. A couple of things to consider here.

For example, if you wanted to continue to protect the dollars that move from freestanding to hospital-based you might end up with more than one rate. But in the same breath we were talking about, should this $4 differential continue? So there's a couple questions here.

Another question is if the money is in fact going to change hands, part of the reason it changed hands is because the two different types were reimbursed differently for drugs. One was actually profiting from the AWP spread and one was being paid on reasonable cost. Which of those was right is the $64,000 question.

MS. DePARLE: Or which profited the most? I also would say, didn't Congress say it was supposed to be budget neutral?

DR. MILLER: They said budget neutral but that --

MS. DePARLE: To me that means it goes to the places where it came from.

DR. MILLER: That's the question. The other question is, if you're going to change hands, should it all go to -- it went from freestanding to hospital-based, but there are other options here. It could go back to the program. It could go to low-income beneficiaries. There are a lot of questions here.

Then on the drugs, I think precisely what the Nancy is setting up here is, we now have at least three different mechanisms. We don't know the incentive structures, and before we say let's do one and rationalize it, we also ought to understand the impacts here because somebody might say, I'm going to move away from these drug regimens if you change to a different reimbursement.

MR. HACKBARTH: Can I add to the list of questions? I wasn't clear as to why when we are going through all of the changes in the payment for separately billable drugs that we continue reasonable cost payment for hospitals into the future. I understand maybe historically why they were treated differently but what was the thinking about continuing that going forward?

MS. RAY: CMS's comment about that in the final rule was that the IG didn't report on that so therefore they

are leaving the reasonable cost method as is.

I just want to follow up on one point that Mark made about the add-on adjustment and what should the composite rate payment be. After 21 years, it raises the issue, do we really know what the costs are? Perhaps some additional research, additional study, time and motion study or something is another option to throw out on the table when you open up this whole can of worms here.

MR. HACKBARTH: Other comments on this?

DR. REISCHAUER: Enlighten me on the conversation you had with Alan in which he said what's the AAC like compared to what we were paying before, and you said, it's gone from $10 down to $9-something but we're adding 50 cents for each needle.

MS. RAY: That's for Epo. But for other drugs --

DR. REISCHAUER: But you came up with a higher payment and I thought some of this profit that we were taking away came from Epo, but maybe it doesn't. Does it all come from other injectable drugs?

MS. RAY: No.

DR. REISCHAUER: Because how could we take it away and then say, but we're going to give you back more than we

took?

MS. RAY: Part of it does come from Epo. Part of it also comes from the other injectable drugs. When you look at the difference between pre-MMA and post-MMA for the other drugs there is more of a difference in the payment rates than there is for Epo. Epo, thinking back to the data, was the smallest difference between pre- and post-MMA, at least was my read of the data.

DR. REISCHAUER: But you suggest that the difference has a difference sign on it in your answer to Alan.

MS. RAY: The average acquisition cost is in fact lower than the pre-MMA payment rate, but now beginning post-MMA, facilities will be paid the 50 cents per administration of Epo.

The other thing I want to say is the average acquisition cost derived from the IG and applied by CMS is the weighted average from both chain and non-chain facilities, and you will see a difference in the profit margin. The IG noted that overall for all injectable drugs there was a 22 percent profit margin for chains versus I believe it was a 14 percent profit margin for other

injectable drugs.

MR. HACKBARTH: Anybody else?

All right, thank you.

We will now have our brief public comment period. Please keep your comments brief and to the point. If someone else makes the same comment in front of you, please don't repeat it.

MS. SMITH: Kathleen Smith with Fresenius Medical Care. The answer to the question that was just being asked is, the reimbursement was reduced from $10 per 1,000 units of the drug administered to $9.72 per 1,000 units. The 50-cent administration fee is per administration. Many thousands of units are given per administration, so didn't raise 1,000 to $9.72 plus 50 cents.

MR. LANE: Larry Lane, Genesis Health Care. I want to thank Senator Durenberger for his comments on the SNF quality issues. I would like to make four quick points.

First, probably to recognize the significance of Sally's comments about discharges from the SNF level, that over half to three-quarters of SNF patients are discharged back to the community. For some of us in this room that have been around the long-term care issue for a long time,

that is a token of tremendous success. We're making some progress.

Second, a zero update will have a negative impact. There's a relationship between reimbursement and staffing. The OSCAR data in fact confirms that, and we have provided that information to the Commission.

Third, would ask that you be very clear on the issue of whether to retain RUG add-ons, that aggregate dollar amount, or to eliminate them. The market basket and the loss to the RUG add-ons in 2006 would account to being almost 12 to 15 percent of the per diem. Translates into about 1.5 percent of the total margin. And if you take certain assumptions about Medicaid, we will be back at a zero margin level and we will have destabilized the profession once again.

Finally would be, a little surprised the Commission has not addressed the issues of how to provide pharmacy under the Medicare Part D to nursing home residents. It is a concern. We do not know on 1/1/06 how the program is going to be implemented and what its impact is going to be on SNF residents.

Thank you.

MR. KENLEY: My name is Rod Kenley. I founded a company called Aksys Limited about 14 years ago that markets a device that it is specifically designed for daily home hemodialysis. Id' like to make a comment in strong support of a rapid implementation of the expanded bundle.

There are probably over 350 clinical reprints and peer review journals that support the significant improvement in clinical outcomes in patients that are dialyzed on a daily basis in their own homes. This encompasses both improvements in mortality, about 2.5 times less mortality, less hospitalizations, and significantly less drug consumption, meaning the patients are much better off and the taxpayers spend a lot less on these patients.

Yet there continues to be disincentives from the reimbursement standpoint for the clinics to expand their provision of home hemodialysis or home dialysis in general. Getting to the expanded bundle we think will go at least part way to reestablishing some of the incentive for home dialysis that was originally intended in the 1983 composite rate. We would highly encourage the commissioners to please resist any attempts to delay the institution of this expanded bundle.

MR. FENNIGER: Randy Fenniger, American Surgical Hospital Association. I would only ask that the record reflect that I got nowhere near a light switch today and was very careful to sit somewhere else.

Regarding the recommendations that were discussed today, as I recall we got into this whole debate because of allegations that specialty hospitals owned by physicians were harming community hospitals. I have yet at any of the presentations your staff has made to see any evidence that such has been taking place. Going back to last month's meeting, in fact that was a conclusion that profits remained approximately the same as other hospitals in 2002, and also that there is no apparent change or no noticeable change or significant change in utilization in the analysis that was presented. So I would have to ask, what are we trying to really address here?

If the issue is really what is called cherry-picking or the deliberate or inadvertent manipulation or movement of cases, the recommendations that have been made regarding DRG changes, if endorsed by the hospital awful industry and accepted by Congress, would seem to deal directly with those kinds of issues by eliminating any

financial incentives. So if people invest in these hospitals for a financial incentive and the ability to manipulate cases and profit from it, you will take that away from your recommendations.

This raises the question of whether or not you need to continue the moratorium. I would argue that you do not, because if Congress accepts your recommendations on the DRG changes, the market will take notice. Those people who were planning to enter the market simply to profit will go find some other place to invest their capital. Those people who were planning to develop hospitals for other reasons than profit would still continue to do that and try to make the best possible situation out of it under the new rules.

Several of you spoke to the need for competition, innovation, specialization. I would ask you, who is going to do that? If you take away the ability of physicians to do it, where does the competition come from? I don't have the answer but I think it is something that you would need to consider.

I would note further that in your presentation by your staff in September it was pointed out that hospitals frequently commented or did comment that the presence of a

specialty hospital in their community was a wake-up call and they improved their services. To take away the ability of physicians to invest in these hospitals is a call to go back to sleep. I am not sure that is a desirable outcome for public policy either.

Finally, let me address the grandfathering clause that was in the recommendation, which was a pretty tight grandfathering clause. Sounds like my old Presbyterian minister grandfather.

Grandfathering will not work. The investments that have been made, whether they've been made by the individual physicians, corporations, or hospitals will be rendered valueless very quickly if you eliminate the whole hospital exemption. That is not going to protect the billions of dollars of assets that people have already invested in in various parts of the country. Of course, that's not just limited to physicians, as you know from your own data. That is hospitals like Baylor, that is hospitals like the one in Kalispell, Montana and other places around the country where there are joint ventures between hospitals and physicians to establish these.

I hope you'll give consideration to these ideas

over the coming month and that we will have an opportunity to discuss these further before you take your final votes. Thank you.

MR. WEINBERG: Hello, my name is Tom Weinberg. I'm with DaVita and I'm commenting on the dialysis portion. Ms. Ray, thank you for the report, and especially thank you for noting the issues relating to the difference between hospital-based centers and freestanding centers are paid. If I understood the question Dr. Reischauer, I think about this stuff all the time but it is true that more of the money in the pot, as you put it, of money that was to be put into the composite rate, came from the freestanding centers as opposed to the hospital centers. So over 10 years about $1.8 billion will be shifted away from the freestanding centers' reimbursement because of the way that CMS instituted one add-back payment to see composite payment as opposed to having separate add-backs for hospital versus freestanding.

Then I have two questions, one relating to the audit adjustment, and the second having to do with the payment adequacy predictions for 2005. On the audit adjustment, again thank you for taking a look at that again

and updating that data. That is a very important matter and we appreciate that. I believe from your comments that I understand that a sample in 2001 cost reports were looked at, so I would ask the Commission and the staff to look at the question, are there differences between the audit adjustment experiences among regional and national chains versus single or very small operators of dialysis facilities?

Then second with respect to the payment adequacy for 2005, I'd like to ask to make sure that the Commission and the staff ask and answer the question, is MedPAC using the same predictions of the growth in into what drug spending would have been under the old law as CMS used in predicting what the payment should be when predicting what the update should be? This is important for 2005 but it will also be important for 2006 as we determine whether the intent of MMA, which was to be budget neutral, has been carried out. So is MedPAC using the same factors to predict future spending as CMS used in its final rule?

Thank you.

MR. CHIANCHIANO: Good afternoon, I'm Dolph Chianchiano from the National Kidney Foundation. Briefly, I

wanted to add to the comments about the landscape for dialysis services in the United States, and particularly to point out two administrative developments that could affect, hopefully for the better, the provision of dialysis services in the United States.

First of all, Medicare is going to issue draft regulations which will revise the conditions of coverage which basically have been around since 1976. This is the first time there has been a thorough look at the conditions of coverage for dialysis providers since 1976. That notice of proposed rulemaking is supposed to appear in the Federal Register, or least on the CMS web site, on December 23.

The other administrative development is that CMS has empaneled a group of technical experts to develop clinical performance measures for the treatment of disease among dialysis patients. Here again, that may affect the utilization of vitamin D analogs in the dialysis facilities, and hopefully for the better of the dialysis patient.

Thank you.

MR. MAY: Don May with the American Hospital Association. I have two quick comments.

First on the update for home health and skilled

nursing facilities. A couple things when you look at the hospital-based margins, the negative 87 percent. I know we've talked about cost allocation. I don't believe there's any amount of cost allocation that can explain negative 87 percent. While refinement is on the way, I think the point that Larry Lane brought up about making sure some of those add-ons stay in the base is an important one that the Commission may want to consider next time. That refinement is really needed to make sure that payments improve for costly cases.

I think in the home health area, as Carol mentioned, there's a real need to look at the refinement and the case severity that's happened. These have not had the annual recalibration that happens in the hospital side so the distortions grow even broader.

I think in light of that, until those happen though, something to make sure that you ensure access. A lot of these hospital-based providers have closed. The ones that haven't are there because of the access concerns. They're in rural areas, and a potential need for an update to cover those large losses and maintain access is probably something to consider.

Second, on the niche provider issue. Julian has presented a lot of really interesting and in-depth analysis today that I'm sure we'll all be scanning and waiting for the detail to come out so we can really get into the numbers and look at some of the impacts. Just from what was presented today you can see the wide redistribution and distribution of funding that can happen. Understanding those impacts is going to be very important moving forward.

The point Dr. Reischauer brought up about understanding what may be a targeted look at refinement of the DRGs might bring -- I know you are already overworked as a staff, but maybe seeing what that might bring would be an interesting dynamic to do and could help to understand how looking at different components and the implementation of those may ease the burden of doing this and making some of the payment reforms that are needed over time.

I think short of that, and given the complexity of making these changes, I want to highlight the importance of the draft recommendation on eliminating the whole hospital exception, and as several commissioners mentioned, extending the moratorium to make sure that we have time for those payment reforms to come into place.

Thank you.

MS. LLOYD: Danielle Lloyd with California Hospital association. First, I support everything that Don just said before me but I will move on to health information technology.

Some of the commissioners, and I assume from the discussion of a previous expert panel that I missed, have suggested that financing is not necessarily a very big barrier in the adoption of health information technology. I can certainly share with you that the California hospitals, all of our members expressed that this is certainly the first and foremost problem. We can't even get people at the table to consider other problems such as our relationship with our physicians, and interoperability, and other such things without the money to get things started, or seed money, which we were hoping obviously to get some more money in the appropriations process this year, but obviously that didn't happen.

There's also the suggestion that foundations in the private sector can foot the bill for this. That is true to some extent. They are certainly providing money in number of different areas, but they're not going to fund it

everywhere. Obviously, as you've seen from Jack's presentation on our hospital margins, we have meager if not negative margins. More than 50 percent of the hospitals in California are operating in the red. We just cannot afford this.

So in your considerations of finalizing these recommendations and also in terms of moving forward, I think that the financial considerations definitely should be weighed a little bit more heavily than I think I heard in today's discussion.

Thank you.

MR. HACKBARTH: Okay, we reconvene tomorrow morning at 9:00 a.m.

[Whereupon, at 5:13 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, December 10, 2004.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 10, 2004
9:05 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. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

P R O C E E D I N G S

MR. HACKBARTH: Today is physician day. The doctor is in, right. So we have a series of presentations and discussions related to physician payment issues, the first of which is on measuring resource use. Anne, are you leading the way?

MS. MUTTI: Yes. This presentation is about resource use measurement and it is the same topic we called provider profiling in the October meeting. We just prefer the title of resource use measurement because it better describes the underlying concept.

Today I will briefly review the discussion that we had in the October meeting and present a draft recommendation for your consideration.

Why resource use measurement? The prime motivation for this strategy is its potential to reduce the variation in practice patterns that is not improving patient outcomes. We know from the Fisher and Wennberg work that in regions in the country in which physicians and hospitals are providing many more services, beneficiaries are not experiencing better quality of care outcomes or satisfaction.

This suggests that, in general, if physicians who have more resource intensive practice styles moderated their practice patterns the nation could save money on health care without sacrificing quality.

For Medicare to realize the potential savings implied by this finding, physicians must be able to first assess their practice style and evaluate whether they tend to use more or less services compared to their peers or what evidence-based research recommends. It is also important that physicians be able to consider their resource and quality measure results in tandem, since that's the best measure of value in health care services.

So to explore the potential of resource use measurement, one option is for Medicare to begin measuring the resource use of its physicians. Medicare does have a wealth of claims data, so it is in a good position to feed that information back to physicians on what their practice patterns look like. Medicare would need to develop or attain a measurement tool to interpret the claims data. We talked about some of the various tools available in the marketplace now at our last meeting, and would just note that many of the private sector purchasers are gravitating

toward episode measurement and that it has several advantages over other approaches.

As we also mentioned in October, to be useful whatever measure that Medicare would use should produce accurate results. That is, that the measurement tool should reflect differences in practice style, not differences in the health status of its patient population, not differences resulting from statistical error or incomplete data.

The measurement tool and the results should also be actionable, which means that they should be specific enough and credible enough to inform physicians how they may want to change their practice styles if they feel it is necessary.

A number of implementation issues would need to be addressed. These include how patient care would be attributed to a physician, how risk adjustment will be performed, and what the minimum number of observations or episodes assigned to a physician should be before that physician can be measured.

While we plan to do further work on identifying characteristics of a good measurement tool and successful implementation, you may want to consider making a broad

recommendation for the March report supporting Medicare's use of resource use measurement. The recommendation might be worded as follows: The Secretary should use Medicare claims data to measure fee-for-service physicians resource use and confidentially educate them about how they compare with their peers. The Congress should direct the Secretary to perform this function.

We actually believe the Secretary has the authority to require carriers to perform this function and we understand that there is some activity among certain carriers in this area, and it seems to be primarily related to detecting improper billing. So in any case, we don't think that the effort that carriers are doing now is a comprehensive one. For that reason, Congress may want to give the Secretary a clearer direction of the purpose of the intent here.

With respect to the spending, beneficiary and provider implications, the short answer that we have up on the slide is no impact, but there is definitely a longer answer, which is that our hope is that this would make a difference, that physicians would adjust their practice style when given in a way that would decrease spending and

possibly improve quality of care. Research suggests that this may well occur.

At the same time, the Commission may want to consider options to promote the ability of plans and providers themselves to measure resource use. One approach could be to have Medicare share its data with private purchasers and we understand that this is not currently permissible due to privacy laws that protect physicians' privacy just as any other citizens. Having access to Medicare claims data with physician identifiers would allow private purchasers to better measure the resource use of their physicians and measure more of their contracting physicians.

Medicare might benefit from a spillover effect of this approach to the extent that physicians do modify their practice styles it would likely apply to all types of patients, not just those that are covered by private purchasers. However, as was alluded to at the last meeting, there may be an unintended consequences of this approach, also.

Another possibility, as you discussed yesterday, is to lift the current restriction on gainsharing

arrangements and instead give the Secretary authority to regulate these arrangements. This policy could encourage physicians and hospitals to measure resource use during a hospital stay because now it would allow them to share in the savings resulting from their efforts.

You may want to primarily consider that recommendation in the context of specialty hospitals but it's just worth nothing that it would also encourage and provide another opportunity for resource use measurement.

In terms of future work, we think of this as sort of our first step and we're looking forward to doing more work. We want to look at what characteristics of measurement tools and implementation appear to improve accuracy and the ability of physicians to act on those results. We'd like to identify potential area such as types of services or patients or specialties for Medicare and the private sector to focus their measurement efforts.

On this point, we did provide an illustration in your draft paper of the potential information resource use measurement can yield. There we present what one vendor's approach to resource use measurement tells you about the practice pattern variation between specialists, the

consistency of that variation across regions, and variation within a specialty in a single region.

We hope to do our own work along these lines in the coming months and, at this point we'd like to turn it over and get your comments.

DR. BERTKO: First of all, I'd like to recognize the excellent work that Anne and Kevin have done in pulling this all together. I think the data they've gathered and organized is in a pretty coherent form for something that's fairly technical.

Again, and Arnie's not here this morning. He grabbed me before he left yesterday and said that I should talk twice as much for both of us. I'll try to refrain from that.

On the first part of it, I guess I'd like to strongly support the recommendation, which I think falls under our wider rubric of saying let's measure things, let's disclose them, let's help physicians understand in particular where there are going and how they compare. I look to the other physicians in our group here to make comments upon that.

In particular, from my perspective, as a policy

goal of reducing the cost of Medicare, the expenditures, without any likely deterioration in services or stinting on services, this is one that just by disclosure has the aspect of being a big number. I think Arnie and I have both thrown out a number that says in its most effective form it might include savings of as much as 10 percent, which I think is a small part of the 30 percent or so that Fisher and Wennberg had said. They had a number, I think, which was up near the 30 percent range.

So when we're talking about budget savings in future years, this is not a switch you can just click and recognize those savings immediately. But we've got to start somewhere, akin to the comments on IT and others, and this is a good place to start.

Secondly, on the spillover effects of this, if the promise of the MMA to deliver regional PPOs, particularly in areas that are not big urban areas, are to be realized I would suggest that this is one of the things that the private sector needs to have some access to. The Medicare fee-for-service database is incredibly rich in things. And with the proper controls on the use of the data, I think could be just extraordinarily helpful in again making the

MMA come through and in recognizing some of the savings there while furthering public policy goals.

The last comment is just to say if you haven't looked at the charts there, you probably won't be surprised by the variation. But seeing it in actual numbers is always stunning. And when you put it together with the New Yorker article that we saw that relates it to real people, this is something that I think should be strongly considered by our group in terms of promoting it with Congress and CMS.

MR. HACKBARTH: Let me just add to what John said about the rubric that this comes under. As I said several times in previous meetings, I think that we have reason to expect that given not just the budget deficit but the long-term fiscal challenges facing the Medicare program, demographically driven challenges, that there's going to be growing pressure to economize. My greatest fear is that happens in an environment where we treat all providers as though they are equal and subject them to the same pressure, the same squeezing, when in fact they very a lot, not just physicians but all types of providers.

I think it's incumbent on us to, as John said, begin building tools that will allow us to make more

sensitive, appropriate adjustments as we move into that environment. And that's very much the way I see this. This is an investment in developing a tool that hopefully will get increasingly refined, sophisticated and helpful to physicians in understanding their practice. I think it will take time and investment to get it to that point. I'm not sure you can just open up the box and say this is great. So I have a longer-term perspective in looking at this.

MR. MULLER: Let me add my commendation to you, as well, for this work. Over the last two days and, of course, over the fall we've talked about a number of ways in which one could achieve the kind of ends that both John just spoke to and you have in the chapter. You have the kind of measurement in reporting look here. Yesterday we talked about pay for performance. You have something in here on gainsharing that came up, as well. We talked about electronic health medical records yesterday. And while we didn't discuss it in this session, the expansion of Medicare Advantage.

As you think about those various policy tools and levers and so forth, do you have any kind of sense of ranking of where the bang for the buck is in those? It's

not that one just uses one of those, and obviously a lot of them are used in a complementary way. For example, a lot of the comparative work is obviously advantaged by having electronic records and so forth.

But could you speak a little bit to where the kind of comparative advantages of those various tools that one might use?

DR. HAYES: One distinction that you made in there was between Medicare Advantage and fee-for-service. At this point, we have what, at least 85 percent of Medicare beneficiaries in fee-for-service. And so for my money, at least, you want to pursue tools that allow some work in that area. And this measuring resource use tool that we're talking about here is one that can fit in that.

Beyond that, it's really a function of how many Medicare beneficiaries are in the different parts of the program, be it Medicare Advantage, be it the regional PPOs -- which I guess is part of Medicare Advantage -- but within that sector. I guess what I'm trying to get at here is the key driver is just where are the beneficiaries? And what tool can you use for most of those beneficiaries, the largest number of those beneficiaries?

MR. MULLER: In part, I don't think we generally do this because it's more akin to the return on investment type of analysis in terms of if one went down these courses. Obviously, they all have a lot of intrinsic merit.

But if in the world of CMS constantly being overloaded with all the tasks, especially after the Act last year, we've spoken for many years about just the general strain on their administrative capacities. Perhaps -- and it's not something we're going to do in the next month or so -- but as we keep developing this theme, and as you mentioned this theme is not going away anytime soon -- perhaps considering where in comparisons one might want to push investment in terms of what we know about both likely outcome, ease or difficulty of implementation, et cetera. So that might be a course for us to consider, again not in the next month, not to make Mark nervous, but over the course of maybe next year.

I think we've all, those of us who have been watching Jack's work for 30 years, you keep asking yourself why doesn't this get more traction? Obviously inside the policy community it has gotten a lot of traction in the last year or two or three. But thinking about what steps one

takes to implement, I think, is important because if, as either Kevin or Anne said, just on the face of it people would act on it, it would have happened a long time ago because a lot of this information has been out there for a long time. So thinking what policy tools one wants to use and what kind of order, I think, is a fruitful thing for us to consider.

DR. MILLER: This is not exactly on your point but you also mentioned the resources and the ability of CMS to respond to these things. And as you think about the last couple of days, we've asked a lot of things and there's definitely an issue there of how much they can do, particularly given what's going on what MMA.

But one point here is that they also have greater contracting authority now and the ability to pick specialized contractors to do specialized types of work now. That would still take money, but it does also mean that you could perhaps envision something like that and not having a central office, a huge impact on central office activities. You could see if you could handle a lot of this through a specialized contractor.

It still has implication for the agency. That

have to oversee it. They have to make sure that the data travels to the contractor. There is some possibility. That's not to ignore your point about the priorities, that's well taken.

DR. NELSON: Physicians are understandably concerned about economic credentialing, tiering, profiling, exclusion from plans because there's been some unhappy experience with the private sector in the past on that. Having said that, there's no question about the need to reduce waste and I'm not arguing with this recommendation a whit. I fully support it. Everything we can do to reduce waste is important to do.

I always remember that the best internist in our group was a man who remembered every diagnosis he'd ever missed in his whole career. He was a high utilizer because one person's wastefulness is another person's thoroughness. Obviously, practice guidelines are a good approach to use that.

The point that I want to make in all of this is while confidential sharing of information with providers, physicians and others, makes sense and will be accepted, it will be accepted with some suspicion about what comes next.

And if what comes next is public disclosure or, God forbid, exclusion from Medicare-based economic performance in the absence of really good severity adjustment, then obviously there will be a real concern about patient dumping and adverse selection in order to protect your profile. I think we just have to bear that in mind.

That's not an issue as long as the information remains confidential. But if it starts being publicly displayed, then we're going to have to make sure that there's a adequate severity adjustment.

DR. CROSSON: I support this direction, also. I think it makes a lot of sense. My own life experience would suggest that the large majority of physicians have an honest desire to the right thing.

As Ralph said, Jack Wennberg's life work provides information, though, that that right thing seems to be different in different places and at different times. And the reason for that is complex, or the set of reasons for that vary. Some of it has to do with different cultures that appear to be supply related that arise in different parts of the country. And then there's other patterns of care that don't seem to have any good reason other than it

just happens to be the custom that has developed over a period of time.

I think this tool works. I know it works. It's one of the tools that has led to, I think, the success over time of prepaid group practices for a couple of reasons. Number one, there is, in that setting, the infrastructure to collect the information in the first place. There's a culture of acceptance, generally speaking. And there's also the natural peer group in that setting that allows disclosure within that group and creates some of the constructive pressure to use the information.

There is, as has been mentioned, a sort a hierarchy here that moves in two directions in terms of the utility of this information. The first level of utility is just awareness. That is awareness by the individual practicing physician. It's also the safest, I think, the least controversial in many ways.

Perhaps more effective than that is disclosure to some sort of peer group. As I said, in some group settings that peer group is readily available. In other settings one could project it might be more difficult to construct. But that is a different level -- it creates a different level of

feeling of competitiveness among physicians which can be constructive. It also then raises, as has been mentioned, the barriers and the concern about this.

Finally, the next level would be the addition of incentives connected to the performance. I think that both increases the effectiveness and potentially also raises the barriers. Somewhere in there, over time, there needs to be judgment made about matching the level that's used with the accuracy of the information at least, as has been mentioned also.

But in general, I think this is exactly the right thing to do.

DR. REISCHAUER: I thought you folks really did a nice job condensing a lot of information and providing us with a feel for this. But of course, my reaction was the more you gave us the hungrier I got.

I particularly was interested in these variations and sitting scratching my head trying to think why do dermatologists and ophthalmologists have these huge variations? These are adjusted for variations in the diagnosis or whatever it is, and we don't know the outcomes so we don't know if somebody who used a lot of resources

cures the person and the other ones don't.

We also don't know does this measure adjust for the instance in which one provider is viewed as unsatisfactory by the patient, so after going to dermatologist A and being told well, there's really nothing much you can do, that individual goes to dermatologist B and gets a whole a set of services, whether there is an adjustment made for that kind of situation.

DR. BERTKO: Bob, let me try to address that one. I think Doug Cave, who I think is the source of this particular data, and because this is episode-linked, in the case that you hypothesized here if there were two visits but triggered by the same incident or diagnosis, those would be lumped together. And so probably one of the two would own the episode or possibly both.

DR. REISCHAUER: Even if they were both dermatologists so the person that then lavished the services on would also get, in a sense, the burden of the earlier --

DR. BERTKO: That's likely to be true.

DR. REISCHAUER: The next little rumination here is what is a region? Upper Midwest Region I, I mean how big a thing are we talking about here? And is it really a

market area? I was thinking of the relative supply of dermatologists. Would I, as a beneficiary, look at all of these people as equally probable source of care? Or is the upper Midwest half of Michigan? In which case there could be submarkets within this and these could be reflected -- all of the dermatologists in the suburban Detroit area could be in the 10th decile because there's a whole lot of them. And to maintain their incomes they provide a lot of services per beneficiary.

DR. HAYES: Our understanding is that these market areas correspond pretty closely to Medicare payment localities for physician services, of which there are 89. So in general, we're talking about metropolitan areas being single localities and the rural areas outside of the Metropolitan areas in a state being another locality. Now, there are exceptions.

DR. REISCHAUER: What I was interested in is would these people really regard who we are saying their peers are as their peers? If it's a metropolitan area, I think the answer is yes. If it's northern Michigan versus Southern Michigan --

DR. BERTKO: Let me expand on Kevin's statement

here. Separate from the tables you saw, those of us using it would typically isolate a metropolitan statistical area, let's say Cincinnati, which would include the Cincinnati, Ohio counties, a couple of the Northern Kentucky counties. And it would be the places where people could normally, who worked in downtown Cincinnati, live and go to. And to the best of my knowledge, from our contracting people, it is looked at as their peer group. It's not the formal type of grouping that Jay would have in his organization but it is literally the community of say dermatologists who operate in the Cincinnati area.

DR. SCANLON: Remember, there's only 89 and that there's about 250 MSAs. So there has been a lot of compression. A number of these might correspond to what might be --

DR. REISCHAUER: A number of them have to be very, very big. I understand that. Undoubtedly, the whole of North Dakota is part of one of these, not to pick a state at random.

DR. SCANLON: I also want to say this is an excellent job, in terms of highlighting an issue that we should have addressed many, many years ago. The fact that

Jack Wennberg has had 30 years of providing us this kind of information and we haven't reacted is very lamentable.

I'd like to underscore what Ralph started and what Mark commented on, as well, which is the issue of the challenge that this may present to CMS in terms of existing resources. And it also suggests that maybe we even want to put some of that into the recommendation. I know that you talked yesterday about keeping the recommendations simple and putting things into the text.

But this issue of CMS resources is something that is truly problematic. Only this week again the GAO reports on the 1-800 number. And while people may point to CMS as the problem there, having come from GAO and having dealt with Nancy-Ann while she was at HCFA on many of these issues, in some respects you sort of feel guilty issuing a report like that because you understand being given an impossible task and being stretched so totally thin that you can't manage all kinds of different activities. And this is the natural result. And only by the grace of God you're not in the same position because you haven't been given that impossible assignment.

This issue has been raised repeatedly but it

hasn't been resolved. It's important as we talk about making Medicare much more viable, much more efficient for the future, that it's not going to come if there's not the investment in administrative resources. This is a good example where there may be a return on investment. So the authorizers can go to the appropriators and potentially make a case that we really need to think about increasing the resources.

So I would encourage us to think about modifying the recommendation some to underscore this point, that it's not going to be done at zero cost. It shouldn't be done by bumping other things which may have equal priority, but that's what would happen if this came through as a mandate to CMS. They would have to think about what are we going to substitute?

DR. MILLER: Can I ask a couple of you to comment on this, and I don't disagree with your point. Is it worth making clear that resources can mean more than just dollars? Because I think sometimes -- and Nancy-Ann, you may want to comment on this or not -- that there's also flexibility issues. The contracting reform gave the agency a lot more flexibility to go after things in a certain way and there

may be other flexibilities.

So I don't disagree with the comment but we might also want any more global about --

MS. DePARLE: Yes, and thank you, Bill, for raising this. I do agree, not surprisingly, that I actually think we should have a more global recommendation on resources because while I think we can acknowledge that Congress in the last year has given the agency more resources, it's not clear that those will be long-lived or the extent to which they're just dedicated to the new Part D. And a lot of what we been talking about, the pay for performance, this, a lot of the efforts that we take need to be made around data collection, will all require an investment of resources, whether it's staff for CMS or just more contractors or, as you pointed out with the GAO report the other day, people to do oversight, to make sure things are really happening.

I would heartily endorse the idea of some sort of a more global recommendation.

DR. BERTKO: Let me only opine as not a professional opinion but one on Ralph's question, which I think is a very good one. Where do you get the bang for the

buck? And out of his five here, I will say that the two big ones, I think, are this IT in two ways.

First of all, if you're making an investment -- and Nancy-Ann, I'll look to you in your new role and say if you're looking for an investment in something you look for a university that's big. And 30 percent of Medicare dollars are gigantic. Whether we get to five, seven, eight, 10, 12 percent of that, it's a worthwhile goal and it's something that some of us on the under-65 side have begun to achieve.

The IT one, which I think is the same size, is longer off. I'm part of a company in the decision team that invests $100 million a year in IT, which is small in this concept but big for our company. The pay-off on those is long-term. We need to do it. I was part of an older company that went out of business because it stopped doing it -- at least out of this business -- and I would ask Jay maybe to comment on that.

But the two of these would seem to be, by dollar-wise, far and above potentially all the other ones rolled up together. Even as good as they are, I mean P-for-P and other things do have potential but will they have big dollar changes? Probably not as much or they'll be even further

out than the IT one.

MR. DURENBERGER: I think my comments will be in the same vein, but they're really addressed to the nature of the recommendation.

I thought the work was great so I took it and I called a bunch of health plans in Minnesota and they're all using it. They come back with very, very interesting results, as John knows only too well and as do others in terms of variation, even in the great place like Wobegon and all of that sort of thing. And there are specific recommendations about where to focus and so forth.

And they also recognize the fact that it's one thing for the health plans to have this information and it's quite another to get the physicians to change their practice.

So then you look in a community like ours to an institution that already exists, like the Institute for Clinical Systems Improvement, which does that sort of thing and it doesn't need the Secretary to tell them to do it. You cross the border over into Wisconsin and you look at what now a 19-member physician group collaborative is doing along the very same line.

The point I think I'm trying to get to is if we could use a couple of weeks to think about a better way to say what we really would like to get done, other than that Secretary Gingrich should use claims data to educate physicians. I mean, it just doesn't strike me as being a realistic -- and I understand about contracting and things like that. But I'm just sharing with you -- and I went through -- the imaging thing is like this. Some of the other recommendations are like this and, like all the rest of you, I'm all for this stuff.

There's something about telling the Secretary that he's going to have to do this and then he's going to have educate all these docs without my better understanding of what it means when Secretary Gingrich or Secretary DeParle or whoever it is, is going to do it that flies in the face of the way it actually operates in communities like Jay comes from and other places. So that's one part of it.

MR. HACKBARTH: I want to make sure that I understand. Without committing to particular language, could you just suggest how you would change this?

MR. DURENBERGER: No, I can't. I can't because maybe you substitute the Medicare program or something like

that, or maybe it's an additional sentence that gets to the point of how the Secretary will use the data to educate physicians that's bothering me just on the basis of what I have seen in our own community about the way you can effectively -- and it's done within groups. It's done within something like the Institute for Clinical Systems, which gets through the whole system.

MR. HACKBARTH: But let me just pursue it because I really want to understand where you want to go. I think that sort of embellishment, enrichment of the recommendation, I normally think that's what the subsequent text is best for doing, as opposed for trying to shrink it down to a sentence or two. I almost want, in a sense, the relatively simple recommendation to call the reader to now read the subsequent paragraphs to get a fuller understanding of what this means, as opposed to try to cram too much into the recommendation. That's my thought.

MR. DURENBERGER: I'm with you. Again, I wish I had an answer but I don't have an answer, so let me go to the second one which relates to the discussion we've been having, which is the issue of resources. It's real. No matter what we say about it, it's going to happen. The

resources won't be there. The priorities will be different and you'll have some secretary walking out like Tommy Thompson did last week saying I wish I'd done this, I wish I'd done that. And everybody knows the reason he didn't do it is because Josh Bolton told him he couldn't do it or whatever the case may be.

And I just had one of these examples. We've launched, after September of last year, launched this effort to pay for quality with certain kinds of physician groups over a certain size. One of the largest ones in Minnesota has just written a letter to the Secretary saying they intend to withdraw from this program. Why are they withdrawing from the program? Because OMB has changed the so-called bonus payments for this Institution.

This particular institution is a world leader in diabetes treatment. It said why ask us to do diabetes? We're going to go to congestive heart failure. And then somebody then tells them how you're going to do congestive heart failure and changes the rules of the game once they're into it. And then they have to write this letter saying, you know, we wanted to use our leadership in these various fields to educate ourselves and other people about how to do

it but then the plug gets pulled.

I don't know where that takes us in terms of a bunch of words but it takes me to an emphasis on what Jay was saying earlier about the way in which systems of care and communities that sponsor, if you will, systems of care and connections between health plans and physician groups or clinical systems and so forth can be appropriately rewarded, which sort of like takes the whole thing to another level of implementation, which you may not want to get into simply when we're talking about resource use.

But I wanted to express it now rather than repeat it when we get to some of the rest of these sort of things because the same general concern applies in each of the way these recommendations get worded. This is so important. It's got to get done. Humana can't do it as well as they could, nor could Health Partners or a lot of the people in Minnesota get it done. And they could do it faster if, in fact, Medicare was behind them.

I've expressed my concern. Thank you.

MR. HACKBARTH: Other comments, questions? Okay, good work. Thank you.

Next is imaging.

MR. WINTER: Sorry for the technical difficulties there. I think we got it straightened out.

I'll be talking about strategies for managing the use of diagnostic imaging services in fee-for-service Medicare. At our October meeting we described tools used by private plans to control the use of imaging procedures while ensuring access to appropriate care. We also highlighted similar approaches taken by Medicare and other government programs. That discussion provides the context for the policy options that I will present today.

Before we get to the options, I want to quickly review the different steps involved in an imaging procedure. Starting from the top of the chart, the physician decides to order a diagnostic test for a patient. Next, a provider performs the study. The provider could be a hospital, physician office or freestanding imaging center. If the provider is paid under the physician fee schedule, it bills for the technical component. Finally, a physician interpret the images and writes a report which is sent back to the ordering physician. The interpreting physician bills for the professional component. The same physician can both perform and interpret the study, in which case they submit a

global bill that includes both components. In addition, the same physician who orders the study, that is the one treating the patient, may also in some cases perform and interpret it.

We're going to discuss policies that would affect different steps of this process, so please keep this diagram in mind as we move along.

Here are the options I'm going to talk about today. The first set are based on approaches being used by several private plans. The second set are ways to clarify the Stark self-referral law as it relates to imaging services. In considering which options to recommend, we weighted the likely administrative costs against the expected benefits.

The first option is to educate beneficiaries about the risks, benefits and appropriate use of imaging procedures. The risks can include overexposure to radiation. The goals of this effort would be to help patients make better decisions about their care and to counter demand stimulated by direct-to-consumer marketing. This option would primarily affect the first stage of the process in which a physician orders an exam. At this point

patients can express their preferences about whether a study should be ordered and, if so, what type. Several private plans are engaged in educating their members but the effectiveness of their efforts is not been studied yet. CMS could launch an education campaign using tools like pamphlets or its web site. It could also encourage physicians to inform beneficiaries about the risks and benefits.

Here's the first draft recommendation: the Secretary should educate beneficiaries about the risks and benefits of imaging, including the dangers of radiation exposure associated with overuse of imaging procedures.

We estimate that there would be no impact on Medicare spending, although the administrative costs for CMS could be high depending on the design of the program. We estimate no impact on providers. The recommendation could result in better quality care for beneficiaries but we don't have specific evidence to support this.

The next option is to measure physicians use of imaging services. This could be done as part of the broader initiative that Anne just discussed or done exclusively for imaging. This would focus on the physicians who order the

studies rather than those who perform and interpret them. CMS would develop measures of imaging volume per beneficiary for patients seen by a given physician. CMS would then compare these measures to peer benchmarks or clinical guidelines and confidentially provide this information to physicians. The goal is to encourage physicians who order more tests than the average to reconsider their practice patterns.

Which leads us to draft recommendation two: the Secretary should measure fee-for-service physicians use of diagnostic imaging services and confidentially educate them about how they compare with their peers. The Congress should direct the Secretary to before this function.

Although we are unable to estimate any spending impact, this initiative has the potential to reduce spending by encouraging the more prudent use of imaging services. In addition, Medicare's administrative costs should be relatively low. We think that this could lead to better quality care for beneficiaries with a minimal impact on providers.

The next option relates to coding edits for imaging services. Private plans use three types of edits

for imaging claims. One type of edit detects unbundling of services which is when a provider submits a claim with two related billing codes and one code is a component of the other. Another type of edit detects mutually exclusive services, which are procedures that should not be performed at the same time. The third type of edit adjusts payment for multiple procedures done on contiguous body parts. Many plans pay the full amount for the first service but a reduced amount, usually half, for the second service.

The first two types of edits apply to both the technical component and professional component of a procedure while the third type applies only to the technical component.

Although Medicare has developed edits for unbundling and mutually exclusive procedures, some private plans have more rigorous edits. For example, we spoke with a radiology benefit manager that does not pay for both an MRI and CT of the same region of the body because it believes that the second test yields no additional diagnostic information. Medicare does not currently adjust payments for multiple imaging procedures.

Draft recommendation three is the Secretary should

improve Medicare's coding edits that detect unbundled and mutually exclusive services and reduce the technical component payment for multiple diagnostic imaging services performed on contiguous body parts. CMS may want to consult with private plans and radiology benefit managers about the coding edits. CMS should also communicate these edits in advance to physicians so they can bill correctly.

We expect that this would reduce Medicare spending although we don't know by how much. The administrative costs should be small. Private vendors estimate that coding edits reduce imaging spending by about 5 percent for their commercial plans. The provider implications would be small and there would be no impact on beneficiaries.

The next option is to set quality standards for imaging providers. These would apply to the providers who perform the study and bill for the technical component. There's some evidence that the ability of providers to furnish quality imaging studies may vary. For example, Blue Cross Blue Shield of Massachusetts inspected 1000 imaging providers to evaluate the quality of their technical staff, equipment and other features. The plan found that 31 percent of the sites had at least one serious deficiency

such as equipment that was not properly calibrated. Poor quality studies can lead to repeat tests, missed diagnoses and inappropriate treatment. For example, a study published in the Journal of Vascular Surgery found that non-accredited vascular ultrasound labs produced a relatively high number of inaccurate carotid ultrasound exams. If not detected, these inaccurate findings would have led to the wrong treatment for the patients. Several private plans require outpatient imaging providers to meet basic standards for the imaging equipment, technicians, quality of images and patient safety.

As we discussed on October, the federal government has set standards for some modalities such as mammography and Medicare has developed standards for some settings that provide imaging such as IDTFs or Independent Diagnostic Testing Facilities. However, there are currently no national Medicare standards for imaging performed in physician offices. The one partial exception is that some carriers have set standards for vascular ultrasound studies that apply to physician offices as well as hospitals. We think it's important for CMS to set national standards for each imaging modality that would apply in all settings.

Because CMS has limited resources, it should select private accreditation organizations to ensure that providers meet the standards. CMS should also have the power to change the list of deemed organizations. Several groups currently exist that accredit different kinds of imaging facilities.

Draft recommendation four is: the Congress should direct the Secretary to require that all diagnostic imaging providers meet quality standards for imaging equipment, nonphysician staff, the images produced and patient safety protocols.

We estimate that this would reduce Medicare spending because it should reduce the need for repeat tests but we are not able to quantify savings. CMS's administrative costs should be relatively low because it would deem private organizations to verify Medicare standards. Some imaging providers may incur costs to meet the standards. For example, they might need to invest in newer equipment or higher credentialed technicians, although many providers already receive private accreditation.

This recommendation should lead to better care for beneficiaries because improving the quality of imaging

studies should increase diagnostic accuracy.

The next option is to develop standards for physicians who wish to bill Medicare for the professional component of imaging studies, which includes reading the images and writing a report. As with the performance of the study, the quality of the interpretation may vary by provider. CareCore, which is a radiology benefit manager, examined a sample of imaging reports produced by non-radiologists. They found that many of the reports lacked key demographic and clinical information on the patients.

The goal of standards would be to improve the accuracy of imaging interpretations, and thus diagnosis and treatment, reduce the need for repeat interpretations or tests, and reduce the incentive for less qualified physicians to self-refer, that is to order studies and then perform and interpret them using equipment in their own offices.

Several private accreditation organizations set standards for physicians who interpret imaging studies. These standards are based on formal training, continuing medical education and experience interpreting a certain number of studies. In some cases, experience or specialty

certification can substitute for formal training.

CMS should use similar criteria to set standards for physicians who wish to bill for the professional component of a study. CMS should select private accreditation organizations to ensure that physicians meet the standards and should have the power to change the list of deemed organizations. To ensure that beneficiaries have access to imaging services, CMS may wish to apply less stringent standards for physicians in medically underserved areas.

Although private plans sometimes restrict payment for imaging procedures to certain specialties, Medicare may not want to do so. The practice of medicine is evolving quickly and specialty training may change over time. Thus, CMS should consider developing criteria that are flexible enough to allow physicians of different specialties to receive payment.

Draft recommendation five is the Congress should direct the Secretary to develop standards for physicians who bill Medicare for interpreting diagnostic imaging procedures. The standard should be based on the training, education and experience required to interpret studies. The

Secretary should have the authority to set less stringent standards in medically underserved areas.

We expect this policy to reduce Medicare spending because unqualified physicians would no longer be able to bill for interpreting imaging studies. The administrative cost for CMS should be low because the agency would deem private organizations to verify the standards. There would be some impact on providers because some physicians may be unable to meet Medicare standards or may have to gain the experience and training to meet the standards. We expect that this would improve the quality of imaging studies received by beneficiaries.

Now we're going to move on to the topic of physicians self-referral of imaging services. Private plans we spoke with expressed concern about physicians ordering high-cost studies and providing them in their offices. There is evidence that physicians who invest in imaging facilities or have equipment in their offices order more tests than other physicians.

The Stark law prohibits physicians from referring Medicare or Medicaid patients for certain services to providers with which the physician has a financial

relationship. This applies to designated health services which includes radiology and certain other imaging services that are mentioned in the statute such as MRI, CT and ultrasound.

However, the Stark law and the final rule issued by CMS allow physicians to engage in several activities with regards to imaging. They can own facilities that provide nuclear medicine services, including PET scans, and refer their patients there. This is because CMS has said that nuclear medicine is not a designated health service covered by Stark.

Physicians can also provide imaging and other services on their own office practices under the in-office ancillary exception. The rationale is that some tests, such as x-rays or clinical laboratory tests, may require quick turnaround time and we are not recommending any changes to this exception.

Physicians can also own entities that provide services and equipment to facilities that are covered by the self-referral prohibition. We'll discuss the first and third issues in greater detail.

In the Stark final rule CMS had to decide which

specific services should be included as radiology services under the Stark law. The Agency decided to exclude nuclear medicine services because they believed that are not commonly considered to be radiology. However, CMS has recently said that it plans to issue a rule that would add nuclear medicine to the list of Stark covered services.

We propose recommending that CMS make this change the following reasons. One, there has been rapid growth over the last four years in the use of nuclear medicine procedures paid under the physician fee schedule. Second, CMS has been expanding the conditions for which it will cover PET procedures, which creates opportunities for the increased use of these services. And third, it appears that there is room to classify nuclear medicine as a radiology service. For example, the examination used by the American Board of Radiology to certify diagnostic radiologists includes nuclear medicine.

Draft recommendation six is the Secretary should include nuclear medicine and PET procedures as designated health procedures under the Ethics in Patient Referrals Act.

This would prohibit physicians from owning nuclear medicine facilities to which they refer patients but they

could still provide them under the in-office ancillary exception.

We expect there would be some savings because there's evidence that physician ownership of facilities providing nuclear medicine services leads to higher use. There would be an impact on physician who own nuclear medicine facilities. We don't think there would be an impact on beneficiaries.

I'll move on now to the issue of physician ownership of entities that provider services to facilities that are covered by Stark. I'm going to use this diagram to explain what the Stark final rule prohibits and allows.

It prohibits physician A, at the top, from owning the imaging center at the bottom right if he or she refers patients there. However, physician A can own a company, at the bottom left, that leases equipment to the imaging center for a per service fee. Every time the imaging center uses the equipment to do a procedure, it pays the equipment company a fee and the physician investor receives a share of that fee. This creates a financial incentive for the physician to refer patients to the imaging center.

The Stark law was intended to minimize these

incentives because they could lead to overuse of services. We've heard anecdotally that these arrangements are being developed between imaging providers and physician-owned equipment leasing companies. These arrangements are allowed because CMS defines physician ownership under of the Stark law as ownership of the entity that actually submit claims to Medicare or Medicaid. Physicians can own companies that least equipment or services to providers without any restrictions.

Draft recommendation seven is the Secretary should expand the definition of physician ownership in the Ethics in Patient Referrals Act to include interest in an entity that derives a substantial proportion of its revenue from a provider of designated health services.

This change would prevent the creation of physician-owned companies whose primary purpose is to provide services to facilities covered by the Stark prohibition on self-referral.

The Stark law gives the Secretary the authority to define ownership so we don't think that this would require a statutory change. We expect that there would be some savings because this would prohibit arrangements that could

create financial incentives for physicians to refer patients for additional services. There would be some impact on providers in terms of limiting the types of companies from which they could lease equipment or services and there would be no impact on beneficiaries.

This concludes the presentation and I would be happy to answer any questions.

MR. HACKBARTH: Let me just try to frame the discussion for second. As I listened to Ariel talk about recommendations one and two, I saw some connections to the discussion we just had with regard to resource management, in particular with recommendation one, the beneficiary education. We have often noted many, many issues on which we need to invest more effort in beneficiary education and there's a shortage of resources to do that.

So that raises the question in my mind where does this fit in the hierarchy of beneficiary education needs. So that's one question.

Recommendation two obviously is a very direct link to the resource management discussion and what I'd like to ask is whether we think it makes sense to have a separate recommendation here or maybe just the one resource

management recommendation with cross-references between the chapters and discussion?

So I'd like reactions to those questions.

DR. STOWERS: First, Ariel, I think it's a great chapter but I've got a few comments I'd like to make along the way, and we've talked about it.

First, I think if there was ever a chapter that it's important is set the right tone and have a good broad overlook from every angle, it's probably this one because in the physician community there's probably not a more sensitive area right now because it involves so many specialty societies and that kind of thing. So I think we have to be very careful throughout the chapter when we mention one specialty society that might be doing accrediting or whatever, to be mentioning several and that sort of thing.

One of the things on tone right off the bat that kind of bothered me, and I don't think it's the intent. It seems that when the intent behind all of this has to do with the more expensive tests, the ultrasounds and the nuclear studies and that sort of thing that might be performed in the office, but there are several sentences and one in your

presentation that say setting standards for physician interpretation reduce the incentive for less qualified physicians to provide imaging service in their own office. And then, in our chapter on the next page, some physicians who ordered imaging studies also performed them on equipment in their own offices rather than referring them elsewhere.

I think we run the risk in this, if that was to be held literally, of really affecting access to patient care and for sure quality of patient care, because it's perfectly appropriate in my mind, that if somebody comes into my office and I have physician-owned equipment in there to do radiology and it's some distance to the hospital for me to do a follow-up chest x-ray on their pneumonia, as opposed to the elderly patient having to do a 10 mile round-trip in traffic or 20 miles rural or whatever, to do that. Or for a patient with a fracture that comes in to get a cast removal. It would be absolutely silly for them to have to make a trip to the hospital at that point, rather than just walk down the hall and get a quick film on there.

But yet the chapter doesn't reflect -- I know you mentioned it a little bit a while ago about convenience and that kind of thing. But I think we have to be very careful

about that access.

And another thing, it's much more economical under Part B for that to be done in the physician's office, sometimes by three-to-one, of what it would be if we referred them on over to hospital to get that done.

MR. HACKBARTH: Ray, I share that concern. I don't think we want the message to be that we are against imaging studies being done in the physician office.

DR. STOWERS: I think this chapter really sent that message.

MR. HACKBARTH: I think what we want to say is that if they're done A, the equipment has to be properly maintained, the technicians have to be capable of running the equipment, and the person who reads the image needs to have appropriate qualifications to do that. There are many types of physician organizations that have this built-in capability and I think that's appropriate for all the reasons you identified.

What I worry about is the proliferation of the equipment and the service being done by people who aren't qualified to do it on equipment that isn't properly maintained.

DR. STOWERS: The second thing I was getting ready to go to is this increased volume from doing that or the amount -- we refer all through the chapters to the number of films that are poor quality or the number of films that might have that be repeated. There's a lot of mights in there that I think on this critical of an issue we need to have some numbers. I mean, is it 5 percent of the films that have to be repeated because of in-office equipment? If we don't have some kind of measurement of that, you wonder if it's worth going into a nationwide accreditation federal system to look at all of this equipment when all states are already inspecting. Every year our x-ray equipment gets looked at. It's inspected. They measure the output. And I'm wondering, and yet we're talking about setting federal -- is there enough bad films and bad equipment in here to really make that recommendation worth implementing? I think if so, the chapter ought to reflect that.

DR. MILLER: I'll take your mind back to a panel that we had. I can't remember now but several meetings back, was it March? Where there was some information presented by -- I don't remember whether it was the plans or one of the management organizations -- talking about what

some of the error rate and the redo rates are.

We also have, since then, talked to several other organizations that do this kind of thing. What they've showed us is their commercial numbers and look at the variation by specialties. In some instances, even their Medicare lines of business.

The thing about these data is that they're not national in scope. If an employer has brought them in and said I need you to help me manage my imaging, it's on that set of lives. So we don't have certainly comprehensive data from a Medicare source that says how many Medicare tests have to be redone or are not qualified. But we do a very strong indications, and you saw bits and pieces of it in that panel, that there is some variation here.

I think the last thing I'll say and stop is that we also -- and Ariel can speak to this much better than I can -- think that there is a lot of variation in how much oversight there is in the quality of the equipment. We have heard that, as well.

DR. STOWERS: I totally agree with that.

DR. MILLER: To build the case better.

DR. STOWERS: To help build the case a little bit

that we're not comfortable with the current system of inspection. But I think we may be in error here not to at least mention that there is a system that's inspecting this equipment out there already, and that kind of thing.

MR. HACKBARTH: Ray, you raised an important issue about whether this is worth the effort. If the numbers are small, as you say, is it worth the effort of going through all of this? In a sense, this reminds me of the specialty hospital discussion.

The dilemma that you face is on the one hand you don't want to do things that are unnecessary that are administratively costly or politically costly. On the other hand, if you let trends run their course, the genie is out of the bottle and you never get it back in.

Frankly, one of the concerns I have in this area is that the genie's trying to climb out of the bottle and we see a proliferation of this things that once it happens it's done. It's in place, you can never reverse it.

DR. STOWERS: Personally, I agree with you. Again, I was just talking about kind of the tone that was set here about that. I think we need to beef that up a little bit. So I wasn't disagreeing necessarily with the

conclusion. It's just that I've already heard well, there's already inspection process going on and all of that. If we really are trying to contain that.

Another thing that is not mentioned in the chapter is that one of the things in our practices that considerably increases volume on the number of x-rays is the radiologist, after they get the films of sometimes not knowing the patient and adding on more and more tests for that reason. And the clinician that's standing here with the patient is saying I don't need that. The patient has already gone home and they're well and that was two weeks ago.

So I think this hedging that occurs, whether it's because of the PLI problem or other things in the country, is a significant factor in increasing the volume that happens long after the patient care is concluded and over with. That may be worth at least mentioning in here as a cost in this volume problem.

MR. WINTER: If I could address a couple of things you mentioned. In terms of the evidence of the effectiveness of facility standards or standards for the physician interpreting the test, there are a couple of published studies that I'm aware of of plan experience. One

of them is the Blue Cross plan that I mentioned in Massachusetts where they implemented standards for both the facility, that is the equipment and the technicians, and for the physician interpreting the test. They did find a reduction in imaging spending. So there's some evidence of that. It's not national. It's based on these two plans.

DR. STOWERS: I just think it may be worth mentioning.

MR. WINTER: We can definitely highlight that more.

DR. STOWERS: And then on the accreditation thing, again I think we have to be very careful again to include all specialties in that. Invasive cardiology, for example, or nuclear cardiology now has a minimum of six months training just on that procedure in order to do it. And yet the inference there is that we may want a radiology or some other specialty overseeing that, which has six months of total nuclear training in their entire residency program.

So I think it was here, except that when we're talking accreditation in the chapter here, ACR was the only name that popped up in the text.

DR. MILLER: If there's any misunderstanding about

this, I want to be clear about it. When we set this problem up, we pointed out how some of the private vendors go at it. They go through and they have CPT codes. And they say these CPT codes you are trained to do and these ones they're not. If you're not trained -- they don't all do this, but one of the strategies.

That is not the strategy we're pursuing. We feel that it's exactly as you said. Things are dynamic, training is changing. And over time, certain specialties may become more proficient than let's say this particular moment at using and interpreting images. And what we're trying to do is set up a process that recognizes that and allows the Secretary to set the standards and organizations to administer it. So that anyone who meets them would be able to bill Medicare.

MR. HACKBARTH: Not specialty-based but knowledge-based. And you can get the training and be certified as having the requisite knowledge regardless of your initial specialty.

MR. WINTER: If I could just finishing on a couple comments you said. In terms of the state radiation control boards, my understanding is that not all states have these

kinds of boards that monitor the equipment in physician offices and other providers. And even states that have them, there are big differences in how aggressive and how well enforced these standards are. There are lots of limitations on resources to run these programs.

DR. STOWERS: This might be a good comment to have that in there.

MR. WINTER: We'll definitely talk about that some more.

And then your concerns about the specialties. I think what we might want to do is in describing the recommendations on accreditation standards and incentives for physicians, is perhaps suggest that the Secretary consult with different specialty societies in developing the standards to ensure that everyone has a voice.

DR. STOWERS: Good.

One other thing that just has to do with -- it's kind of a personal thing with me practicing. I've always wondered about the cost to Medicare where a patient hits the emergency room -- and I'm not talking about when I'm covering the emergency room as a family doc or ER doc, and I have a 15-year-old in a motor vehicle accident and we do

neck x-rays and I have the radiologist overread that and that kind of thing. Not at all.

But when I bring the patient through the emergency room and I obviously see the fractured hip and then I bring in the orthopod and they take them to surgery and before, during and after films are taken throughout that entire process. And then the patients in rehab by Monday or Tuesday. And then we come in and we have -- I had a patient bring me this bill.

Then we have the radiologist overread, or whoever's assigned by the hospital to overread all of these films, which came to -- it got into thousands, low thousands, but to overread all of that care that had already happened and the patient was already -- I wonder about this whole look at overreading, double reading.

Because there's another box actually on the majority of films that occur in your original diagram. And that's a box of the person that's treating the patient often gets a very small fee for the treatment is institute care or the reading of the film to institute care. But then it goes on often for the consultant or the radiologist to look at it.

There's a real big PLI factor in here, I know, that affects the volume. But there's another one that I think is even bigger in dollars that affects the need for secondary and overreading of films when what I think you're going to find is that -- and I'm circling around to where I think if we do go on through this accreditation process, it may actually help that situation. Because if it becomes that this orthopedic surgeon is qualified to read the hip fracture and do that kind of thing, then maybe Medicare can start saving on the back end and the patient can start saving on the back end. Because the deductible that this patient had to pay for the reading of the x-rays was what brought them into me.

So as we get into this accreditation process, I think as we look at the potential savings done the road, that may not be all bad in the process. So I just want you to think about how much of the necessity of overreading and all of that may be something to reevaluate, and when it's medically necessary and when it's not to have that consulting done.

My last point, real quick, is that there is an exponential growth in the amount of radiology services that

are leaving this country. We have multiple hospitals through I know our region of the country and I know through all regions of the country. The two fastest growing readers of our films in the country right now are India and Australia. And some of them are U.S.-trained physicians and some aren't. They can actually, in some of the clinics where I have teaching going on, they can actually get their films back read quicker all digitally than they could walk them six blocks down the street to the radiologist at the hospital to get them done. And I'm talking tens of thousands of films, including Medicare patients.

So as we talk about this accreditation process and interpretation, there's even a lot of physician groups that have the x-ray equipment and we're talking about accrediting who's reading the films. A lot of times nowadays it's not the physicians that own the equipment. They've got an agreement which used to cost tens of thousands of dollars for the equipment. Now it's a few thousand, it's all Internet-based, it's quickly done.

And I think not to mention that somewhere on, this changing trend of who's serving our Medicare patients, is something I think is important right now. At least I know

in the rural areas. But one city that's using this now is over 100,000 and every hospital that I know if in that area is using these type of distant services.

So it gets back to now you can have your radiologist in Hawaii and your hospital is on the East Coast and no in-house radiology and that kind of thing. Because the technology has just come to this point.

The quality is actually, in most cases, better than putting up the regular films and that sort of thing. But it does somewhat isolate the consultive relationship between a physician that's there to help and deal with the patient. It makes it a very kind technical read at that point.

I'm done, Glenn, I'm sorry.

MR. HACKBARTH: Those are very helpful comments.

DR. WAKEFIELD: I only wanted to comment and I wanted to comment on this even before you raised the issue, Glenn, about draft recommendation one as one of the solutions to the challenges in this particular area.

When I was reading through the background text associated with this, I really had a question about whether or not this merited recommendations status, if you will.

Generally speaking, I'm all for beneficiary education. I think it's tremendously important.

But I really wonder whether this is a meaningful way to address the problem? And, even if done across all Medicare beneficiaries, is it likely to make a difference?

I didn't have a sense that we've got as good a data here about this as an intervention. There was some reference to it being done on the private sector. But I just didn't have a sense that the data were there indicating the extent to which it made a difference.

And also, I wasn't exactly sure about any quantifying of exposure. So how frequent is this a problem? How many people are being put at risk? To what extent? I didn't see that well documented, unless I breezed through that too quickly.

I actually am a lot more concerned about the significant risk that I do think was based on some documentation to beneficiaries associated with poor equipment being used. I don't know how you engage a beneficiary there. But that, to me, provided a more significant risk than this one.

So this one didn't bowl me over, as the others do,

in terms of a solution to this problem.

MR. MULLER: Also with regard to recommendation one, some of the evidence emerging is that in the imaging studies, especially some of the more comprehensive ones like the whole body scans, start detecting a lot of things that don't then need interventions but the interventions ensue. This goes back to our discussion of resource utilization and so forth. And I think the field is not as well developed.

I would say the bigger risk now is the interventions that aren't necessary. I say the field is not as well-developed but both in terms of the surgical interventions -- I mean, you see things. And then obviously, once you see things on these, like for example the whole body scans, the patient has a lot of interest in doing something even when perhaps there is no other symptomatic evidence.

So I think one thing we have to be attentive to, again going back to the utilization discussion we had both earlier today and yesterday, is that the magic of this imaging also now starts detecting things that have no other symptomatic expression. And therefore, you start getting a lot of interventions, especially surgical interventions,

that may not be necessary and could probably have more consequence that the dangers of radiation exposure.

So again, where we ultimately decide to go with this recommendation I'm not sure either, based on Mary's comments and yours. But if we do stay with this recommendation, I would at least suggest a partial amendment that also looks at the risks of overutilization.

DR. WOLTER: I had the same concerns about recommendation number one, I would say. And I don't honestly know what it is about the current risks to beneficiaries given the current technology. So that would be one question, how risky is it and how many individuals annually are at risk? And then would this be even the right tactic to reduce that risk if we had data about how much risk there is?

I guess the thing I'm wondering about is if we are ignoring one of the major leverage points to control imaging studies? I think much of the increase in imaging is because it's fabulous technology and what we can do now compared to 25 years ago with imaging and the things it does for us is incredible.

But to the extent there's inappropriate

utilization of imaging studies, I think that pricing and reimbursement is at play. When I look at imaging, it's one of the handful of service lines that allows organizations to achieve a bottom-line. So I hesitate to say this but I think that there is not competition around pricing in imaging, at least in many parts of the country.

Some imaging services are actually not well reimbursed. Mammography, for example. It's very difficult to break even on mammography. However, CT, MRI, ultrasound, nuclear medicine are large margin services and I think that looking at the reimbursement models would be a leverage point for control of inappropriate utilization.

MR. HACKBARTH: At the last meeting Nick and Alan and maybe some others raised the issue of the accuracy of our pricing for this particular area of physician services but maybe some others. And much as we have, in the hospital sector, been saying we've got to look at the accuracy of the pricing and the price signals we're sending, I think some of that applies here as well.

Now we haven't gone into our customary research analytic mode on that. So what I had envisioned we were going to do is identify that as a concern that we have and

an area for further analysis and research.

MR. WINTER: If I could just add to that that the coding edits recommendation, the second part of that does address the pricing issue because the issue there is that you're doing two tests an contiguous body parts. You get paid the full amount for both tests, even though we have reason to believe that there are fewer resources being used for the second test because you've already invested time in preparing the patient and clerical time and supplies. And so there are savings to be gained there. And so this is one recommendation that does address the issue of proper payment.

MR. HACKBARTH: I would like to see some reference to that issue.

DR. MILLER: And not to miss your point, we had -- and actually Bill and I were discussing this this morning a little bit.

We do have an expectation to get back to path on a number of places. We talked yesterday about the guts of the home health reimbursement system. We had talked at our planning session over the summer the notion of looking at some of the parts of the physician fee schedule, the

relative values, some of the geographic adjustment, that type of thing. And once we get over the fury of the next couple months or the workload of the next couple months, try and return to path on those couple of things. So your point is taken and we can note it here in the text.

DR. REISCHAUER: I have a semantic nitpick and then some comments on a couple of the recommendations.

It's our tradition to say the Secretary should in our recommendations and mostly we're talking about process. The Secretary should institute a system of pay for performance or he should develop measures of resource utilization and share those with the docs.

But in some of these cases, we're talking about dealing with the beneficiary and it really sounds a little absurd. The Secretary should educate or the Secretary should measure. You have this vision of the Secretary with his ruler out there measuring something.

And what we really want is that Medicare should get involved in these, not that the Secretary should be doing it. I think we should fine tune the way we make some of these recommendations.

I am positive about recommendation two through

seven but like several other of the commissioners, I am very dubious about recommendation one. We aren't exactly making a strong case where we say it has no spending implications, it has no implications on the providers and no implications on the beneficiaries. You sort of scratch your head and say yes?

And I am dubious, like I think Mary was, that this would have much of an impact. I think it's very important to get this information out there. How you use the information is a little difficult because, as some of the people have pointed out, there is the number of images that are done but there's also the quality of the machine that makes a difference, and probably more of a difference.

But if you were a women of childbearing age or a guy who's worried about where he puts his laptop when he does his computer work, you might pay attention to this. But when we're dealing with a population over 65 and these are impacts that go on and have implications many years down the road, and your doc is saying I want to see what the problem is, you're very likely to be influenced by the change in a probability from one in 10,000 to one of 5000 of getting cancer or something.

So I agree that we should probably have some paragraphs about this but not make a recommendation on this at all.

With respect to recommendation five, this might expose the depth of my ignorance, but it strikes me that this is a huge change in how Medicare operates and one that I'm not opposed to. But we shouldn't treat it like -- and you can correct me -- that it's just sort of a little fill up here or there. Am I not right that if I were a psychiatrist I would be able to bill for some surgery or for fixing a broken bone or something like this? In we're saying yes, but with respect to reading images you have to have this kind of training or that kind in addition to your M.D. And I think if that is all true, we should really make it clear to the reader that -- and this is maybe beginning to move in a long-run appropriate direction which, because we have the tools to do it, we're doing it. But let's make it clear.

With respect to recommendation six, Ariel can educate me on this, but aren't PET scan machines like a couple of million dollars and they weigh a couple of tons? I mean they aren't the kind of thing you'd find in most

offices. They've gotten smaller? So we have a laptop PET scan?

MR. HACKBARTH: MRIs once were the same issue. Oh, nobody would have this in an office. This is too big, too expensive, too complicated.

DR. REISCHAUER: But I think some of the text sort of reads like x-ray, MRI, PET, they're sort of all the kinds of things you could have around the kitchen when, in fact, some of these things really are quite different.

Lastly, I think there are a lot of advantages to having imaging capability within physicians office, convenience, cost, efficiency. And so we want to preserve those positive aspects.

When we get into talking about accrediting the technicians and certifying the machinery, et cetera, which I think is completely appropriate, we shouldn't kid ourselves that this is going to increase the cost of being able to provide that service and to justify that cost some people will drop having these machines in their office. That has its negative dimensions. And others will be tempted to increase volume because you've got to pay for this more specialized technician. You have to pay for the higher-

quality machine, et cetera, et cetera.

My guess is that quality will improve but so will cost. It might be just my CBO reflexes that cause me to feel that, but I think there is a positive cost to this.

MR. HACKBARTH: Let me just pick up on Bob's point about the magnitude of the change implied by the certification. I agree 100 percent, this is a very important change and we shouldn't diminish its significance. I think it's important because of where things seem to be moving as I said earlier, to address issues before they become unaddressable. It is true that a psychiatrist could do surgery from Medicare's perspective. But I think that there are other controls there. The hospital would make sure that that doesn't happen.

The issue here is that we have things moving outside of those institutional structures into physician offices where there aren't any other controls of any type. So I think that's the case for moving ahead here.

I didn't get all the hands on this side, so let's just go down. Jay?

DR. CROSSON: Thanks. First, I want to compliment Ariel for the work. I know how hard he's worked on this.

This was, I think, probably a tough assignment among all the assignments that get passed out.

I do think that among the recommendations there's going to be a difference among them in terms of the likelihood that they're going to be effective in impacting the problem at hand, which is the rising cost. I think I agree with others who said that recommendation number one probably is the weakest of them in that regard. It may not justify the resources.

But I wanted to talk for a minute about the issue of how to really impact the in-office costs of the diagnostic procedures. That may well be, as you just mentioned, the area of most concern. It seems to me that this issue of when to do a diagnostic test, what the threshold is for doing a diagnostic test, the number of different tests that get done as opposed to one, it's the belt and suspenders phenomenon. And then also, the frequency of tests. How many tests to do over what period of time are the relevant issues often.

Also, I think that some of these tests are done kind of one off, that is an odd situation gets the test. But a lot of them are done in a fairly repetitive manner

based upon a given presenting complaint or diagnostic suspicion or something like that. In other words, it's the idea of batteries of tests over time. And that's where the phenomenon kind of accumulates.

To the extent that it is repetitive and predictable, I think maybe some work needs to be done there to identify the situations in which that's true because it's not true in all.

Then it begins to raise the possibility of bundling payment, bundling the payment for professional services with the payment for the diagnostic studies based on an application of some understanding of the frequency with which over a population the studies ought to be done. It's not an idea dissimilar from prospective payment to hospitals for what became DRGs. It sounds complex to think of but I'm sure it sounded at least as complex to the people who were coming up with the DRG idea. I think you can estimate the frequency that a test would need to be done or repeated or three tests instead of one test based upon knowledge of disease processes.

And I'm just wondering whether or not somewhere in here, perhaps related to recommendation two, which really

calls for the development of more detailed information which is provider specific, specialty specific -- admittedly for a different purpose, which is educating the providers. But I wonder whether out of that, and perhaps one justification for having it is a separate recommendation, might be the addition of the idea that it might be worthwhile to gather some information over the next year or two to try to understand in this area where there is that kind of coalescence of commonality such that for selected diagnostic procedures -- and I don't want to name a specialty -- but for patients coming in with this sort of routine complaint that you could begin to bundle payment for professional services and for diagnostic services.

I think then you begin to create the situation, as with other prospective payment systems, where the economics become less of a factor in those discretionary decisions.

DR. MILLER: Ariel, there are two things that were occurring to me while he was saying that. One is is there anything in the editing protocols that we've talked about with folks that looks at any of that, the notion of frequency? I'm going to catch a claim if you're getting your second MRI in a week. Is there anything like that that

we saw? And then secondly, his notion of bundling. In any of our discussions was there this notion of putting the diagnostic and the interpretation is --

DR. CROSSON: I'm not talk about bundling the various fees for the diagnostic procedure. I'm talking about bundling the payment to the physician or group --

DR. MILLER: For the entire condition.

DR. NELSON: Ultrasounds and pregnancy.

MS. DePARLE: You decide how many you do.

DR. MILLER: We touched on issues like that, this was over a year ago, at one point in the commission. We were talking about the fact that they have global payments for post-surgery in Medicare right now, and talked about some of these ideas. So we can come back to some of that and work it up.

DR. REISCHAUER: If we could do that successfully and scientifically, then you wouldn't care about doctor ownership. You get rid of that problem completely.

MR. WINTER: Mark, we learned about one company that develops edits has an edit where they don't pay for a second repeat -- certain repeat tests that are done with a week of the original test by the same physician. So those

kinds of edits are out there. Medicare could investigate using them.

On the second issue, remind me what that was again, that you raised?

DR. MILLER: Bundling on the basis of --

MR. WINTER: We hired a contractor to talk to folks at the carrier level, at CMS level, and outside experts about the different approaches we were considering and hearing about from private plans. One of the ideas that they brought up was the idea that Jay mentioned and Mark, you talked about, the notion of bundling the fee for treating the patient with the fever for the diagnostic test, to encourage greater efficiency. So we've heard about that idea a little bit. It's a very interesting idea.

MS. DePARLE: I, like Jay, want to commend Ariel and Kevin and Anne and the whole team for the work that's been done here. This has been almost two years, I guess, of work drilling into this subject. And I think it's important and I agree with Bob that it is significant and starts on a new path for Medicare, one that is supported by the evidence. They have already started doing a few things like this. I think we talked about the power wheelchairs where

they're now saying only certain docs can prescribe those. But it is new and I think we should recognize that.

I had a couple of comments. On recommendation five, Ariel, this pegs a little bit off of something that Bob said. But we are saying that the Secretary should develop standards for physicians who bill Medicare for interpreting the procedures. And I agree with that. We've seen strong evidence and heard from others' evidence that that is needed.

But I guess I wonder about why it's just the professional component? Because to get to when the wrong test is ordered or when the physician is ordering one that is inappropriate, I mean I guess the earlier recommendation gets to the poor quality of the image. But when the wrong thing is ordered, when one is not needed. And remember here, we've been talking about the cost to Medicare but the beneficiary is paying something here, too. This is a big payment for them.

I wonder how much it is, really? We can look at how much it's grown as a component of the physician fee schedule, look at how much beneficiaries have been paying. Someone referred to them asking for tests, and I'm sure

there's some of that. But I think most of us, when it comes to this kind of thing, are just listening to our clinician say I think we need this.

I just wonder if focusing just on the professional component for this recommendation really gets to what we need. We want to make sure that the clinicians who are ordering these tests are trained to know what to order and when to order. So I don't know how to get to that, but it seems to me that could be more than just the professional component.

MR. WINTER: That's a really good point. And when we talked to private plans, the way that they would get at the issue of the physician knowing when to order the test and what test to order, a couple of strategies they used included measuring the resource use, which we've talked about, and then supplementing that with directly targeting physicians who are high users with specific education in different ways.

Another one is preauthorization, which we've not proposed here and would be very difficult for fee-for-service Medicare to do. But that's one way where they directly evaluate whether a request is necessary, comparing

it to clinical guidelines. So those are some strategies they've used. We have brought in the measuring resource approach to our set of recommendations.

The one about educating beneficiaries was designed to give them better information about what test is necessary and to counter some of the direct-to-consumer advertising that's out there. But everyone has raised very good points about the recommendation.

MR. MULLER: Aren't you talking about stage one in Ariel's first box, versus I thought this recommendation was about stage two.

MS. DePARLE: It is but I guess I'm saying that I think we also heard that a component of this is not just whether the person who interprets the test is really qualified to do it. And then that results in some repeat tests and additional tests, and et cetera. Or necessary tests. But there's also a question of whether, when ordering the study, the clinician orders the right study.

MR. MULLER: Almost any physician can be in box one. A far more limited set can be in box two. Generally, we prefer that to be people who have the kind of training that Ariel mentioned. But a psychiatrist or a neurologist

could be a box one. He can't be in box two, most likely.

MS. BURKE: But Nancy-Ann raises a much bigger question. There is this secondary question, which is once the test is ordered whether the person reading it is the right person to have read it and is qualified.

But the bigger question is has, in fact, the right test been ordered, which I think Ariel points out. Part of that is in the question developing standards and looking over the long-term in terms of resource utilization in practice patterns of individual physicians. But it is the much more critical question that begins the process.

Can I ask a question about the second piece of this, which is the box two, which comes after box one has been dealt with? I'm going back to the point that was raised about the frequency now of that work being referred out, in fact out of the country, but to organizations. And I wonder how the recommendation five would apply in those situations where, in fact, they are now having interpretations done by organizations in India or wherever. How does one, in fact, apply requirements about training and those kinds of details if, in fact, that is happening --

MS. DePARLE: And do they bill? Those outsource

people in India bill Medicare?

MS. BURKE: How does that work?

DR. STOWERS: I think what I was getting at there is exactly what you guys are getting to. You've got somebody qualified to even order the film. Let's say you have really good equipment and you have somebody that is really qualified to read the film. Let's assume all the people I was talking about are really qualified.

What's in the chapter, though, is kind of an inference that if you have somebody really qualified to read the film and you have really good equipment that that's going to affect volume. It's this is in-between thing that you're talking about that affects volume because as these films are sent out electronically and done, they're read at whatever volume they come.

MS. BURKE: Let me parse out the question I'm asking. There is the question of whether the test is the appropriate test. That big question has to do with practice patterns and looking at -- and that does drive volume.

The very specific question I'm asking is when, in fact, it is sent out to be read, when it is referred out electronically to some place, whether it is in the U.S. or

whether it is overseas, I want to understand practically who, in fact, bills for that interpretation? And how does one apply a standards to an interpretation that is occurring in India by some company whose expertise is in reading films? Who actually bills for the interpretation in that setting? And how does one apply standards in that an environment.

MR. WINTER: This is an issue we'll have to look into so more. I wasn't aware of the issue that you guys have raised.

MR. MILLER: Can I just parse through a couple of questions? Here's what I'm hearing. First of all, when you ask the question about --

MS. BURKE: If the state of Montana is going to China to have their films read --

DR. NELSON: By an unlicensed physician in that state.

MR. HACKBARTH: Let's do some research on this. It's an interesting point that Ray has raised. We can't answer it definitively right now. We just don't have the facts. And so thanks for flagging that, Sheila.

The other piece of this, about is the person

ordering the appropriate tests, obviously gets to the heart of the volume issue. Help me physicians here, but I think it's a difficult thing to get a grip on. Sometimes a primary care physician will just ask for a consultation from a radiologist and the radiologist will decide what to do and you're basically asking for help and the decision is made there.

If the equipment is moving into physician offices, it may be that other physicians are deciding what images to order and they may not have the qualifications to do that well. So I think there are lot of different patterns of practice here.

MS. DePARLE: That was my point, is that I think we have more work to do there.

DR. REISCHAUER: But I think the question is whether we should walk before we run, because what you're talking about is part of a much larger issue which could apply equally well to expensive lab tests.

MS. DePARLE: Yes, and I said we had more work to do there. I just wanted to highlight this. I wasn't clear on what we thought we were getting at with that recommendation because I think it deals with a piece of it

and I think the profiling piece of our other recommendation on the resource measurement will deal with some of it. Maybe that's the walking before we run.

My second point had to do with recommendation number six. Here maybe I differ a little bit with what Ray and some others have said. No, it's not six. It's the one about Stark, number seven.

I thought in the chapter we did a good job of discussing Stark and the reasons why there was an exemption from the self-referral laws for in-office ancillary imaging. I'm sympathetic to that from a number of fronts, patient convenience where that's a factor. There may be rural areas where there is not another place to get it done that's convenient, and that certainly is compelling.

I also think that there could be cases where the office payments that physicians are getting are so low from Medicare and perhaps from other insurers, as well, that they are driven to try to do other things to make money, to make a living. I think that may be part of what's motivating this.

But I do think we have some more work to do here. I think what we heard from those plans who presented us was

that they thought this was a big source of the increase in volume. They at least think, in their plans, that there is a substantial part of it that's inappropriate. I don't think we know the answers for Medicare about what's appropriate and what's inappropriate.

I would ask Senator Durenberger and others whether Congress really intended, when they included this exemption, to allow MRI machines in lots of primary care doctors offices who might or might not be really trained to do that kind of work. And we heard, I think, some pretty disturbing evidence, maybe some of it's anecdotal and we need to drill into that, about the quality of the imaging that's being performed. And I think, Bob, you're right, some of it was from Utah because I remember that.

So some of our recommendations will get at that. But I would hope that we will do some more work around this piece of it because I think that is a significant factor.

DR. STOWERS: The only thing I was saying in that, and I agree with everything you're saying, is the inference that all of that is not good or all of that increased volume is not good. Because if I'm in the office and I'm trying to convince a patient that they need to get their cholesterol

done or whatever, and it's a manner of having to go to the hospital when they're busy in their lives and all of that, and sit for an hour until they get through the lab and all the process and redo the paperwork and everything that goes with that, as opposed to being able to come in fasting and go down the hall and get your lab work done.

MS. DePARLE: I totally agree with that.

DR. STOWERS: I'm not disagreeing with all the rest. There's a lot of work that needs to be done but I think we can't just look at it from the side of well, it's increased, and it's bad. That's all I was trying to --

MS. DePARLE: And I think we've made some big steps here. We say it will be difficult to parse out what's appropriate and what's not.

DR. STOWERS: Exactly.

MR. HACKBARTH: We need to be clear, we are not against integrated organized practice. What we are in favor of is qualified people doing it with accurate equipment.

MR. DURENBERGER: I'll be brief. I smiled when Nancy said maybe Senator Durenberger can tell us what people intended.

I had this group of students in Washington in

September and Pete Stark came and presented to them. And of course, one of the first questions was about the Stark bill. And he said actually, much of that was written by Nancy-Ann, Bruce Vladek and all of their predecessors. They just put my name on it. So that's the answer to her question.

MR. HACKBARTH: So it's the DeParle law from now on.

MR. DURENBERGER: I didn't know if he used your name, but he said you know the government did the regulation.

But I want to make a comment about will add section on growth of imaging in Medicare, just a comment on the larger chapter. Because if we look at only this chapter, I'm reminded of a presentation I saw Clem McDonald make recently where he shows this big mobile CT scanner out in front of the church. He says they get there before the first service and they stay until after the last service so all of these Medicare beneficiaries or whoever can troop out of the church and go right through the scanner. That's what this chapter implies about imaging.

There's a whole another side of imaging, the technology, the people who use it that I think needs to be

told. And I would suggest -- I'm not going to try to tell it. I'm just saying that as you present a chapter like this, we ought to talk about how we increase the quality and reduce the cost by moving it out of hospitals. How migration of less invasive diagnostic, how imaging as a therapy, that sort of thing sets up yes, but you need to do this. Just a suggestion.

MR. HACKBARTH: And I absolutely agree with that, Dave. From my perspective what makes this area so compelling is that we have the conjunction of several different factors. One is the technological innovation and the wonderful things that can be accomplished now with imaging and the equipment getting smaller and less costly and being able to move into different settings. We ought to be very clear that those are tremendous developments and we are all in favor of them.

But when you take that development and combine it with frankly the pressure that many physicians feel under income from other sources, combined potentially with mispricing of services within Medicare program creating unusual profit opportunities, it's the conjunction of those three forces that may cause some problems for the program.

And we need to address them earlier rather than later, or things will really get out of hand.

That's my message on this topic. Dave, did you have something to add?

MR. SMITH: Two quick things, and most of what I wanted to say has been said and said well. I won't repeat it.

I had a different concern with recommendation seven than Nancy-Ann's. I was thinking well, what happens if the doc owns the building in which the equipment that the doc doesn't own is utilized and somehow the fee or the rent or the condominium structure is on a utilization basis? Or what happens if the doc owns the company in Banglore to which the images are sent to be read and that company, in turn, bills the doc who, in turn, bills Medicare? I don't know that any of that's true, although I would bet it is all true.

It strikes me that trying to do something as narrowly framed as seven exposes the extent to which it is very hard to keep up with this sort of financial architecture and engineering and it sort of sounds silly if you think about gee, what's next. So I wonder if we ought

to do seven.

It struck me, though, that the some of the problems, the Stark problems that seven appropriately attempts to address, would be better addressed by two things that got raised by people earlier: Nick talking about the pricing anomalies here, which to the extent that they are true, and I have every reason to think that Nick is probably right here, are more likely to be driving volume than anything else. And Jay's notion about can't we bundle this? If we do bundle it, than the problems of being at least as quick to innovate on the regulatory side as entrepreneurs are on the gaming side go away the bigger and more appropriate we make the bundle.

Those are not things we can craft recommendations about between now and January but they are two things that I think ought to be at the center of new and continuing work here.

One other thing. Carol and I live in a market that is bombarded with direct-to-consumer advertising for imaging services. The comfort, the size of the television, the ease, the position as you get scanned now. The notion that the Secretary could speak with a voice that would in

any way compete with what's already out there, if you live in New York, is just preposterous.

MR. DURENBERGER: Or any other place.

MR. HACKBARTH: Okay, we need to move ahead. We've succeeded in falling behind again, but this was a very helpful discussion. I think we really refined our message somewhat through this exchange. Thank you, Ariel, for your good work.

Because we're behind, we're going to have to move quickly ahead to our next subject. Our next subject is assessing payment adequacy for physicians. Whenever you're ready, Cristina.

MS. BOCCUTI: So, as Glenn said, I'll be presenting an assessment of payment adequacy for physician services. Factors for this analysis include beneficiary access to physicians, physician supply and service volume. Then I'll discuss expected cost changes for 2006 and finally present a draft recommendation for your consideration.

In October, I presented findings from three beneficiary surveys on access to physician services. So in a 20 second recap, the general findings from the survey were that the majority of beneficiaries report little or no

problems accessing physicians. A small but persistent share of beneficiaries, however, report having problems, particularly those who are transitioning beneficiaries, those who have recently moved to an area or switched to Medicare fee-for-service. A somewhat larger share of beneficiaries, though still a minority, report having difficulty getting timely appointments.

Medicare beneficiaries have the same or better access to physicians as privately insured people aged 50 to 64. When we excluded beneficiaries over the age of 74, the similarities between the groups remained on almost all measures. Large surveys show slight improvements between 2002 and 2003. Our smaller but more recent survey tracked 2003 and 2004 and did not find statistically significant differences.

So the key point from beneficiary surveys is that we do not have evidence of increased access problems.

We also examined physician surveys regarding the proportion of physicians who are accepting new Medicare patients. In general, the most recently available data indicate that most physicians are willing to accept new Medicare beneficiaries. The most recent survey information

comes from the National Ambulatory Medical Care Survey or NAMCS and results from this survey show that 96 percent of office-based physicians had open practices in 2003. That is, they accepted at least some new patients. 94 percent with at least 10 percent of their practice revenue coming from Medicare accepted new Medicare patients. Each of these rates increased one percentage point compared to the 2002 NAMCS.

So in short, this survey does not find evidence that physicians are decreasing their acceptance of Medicare patients.

This year we added a few analyses of summary claims data to boost our examination of physician supply in the Medicare market. First, we looked at the entry and exit and found that the number of physicians with Medicare patients is increasing. Indeed, between 1999 and 20002, more physicians have entered the Medicare market than exited. By being in the Medicare market, I mean having at least 15 different Medicare patients. And using this delineation prevents us from counting physicians who provided services only on an emergency basis or as coverage for colleagues who were temporarily unable to treat them.

Using this cutoff also provides us with a conservative estimate of the number of physicians in the Medicare market. As shown in this table, physicians who started seeing Medicare patients outnumber those who stopped seeing Medicare patients. And thus, the ratio of physicians to beneficiaries logically increased from 11.7 to 12.3. So although an overwhelming of physicians stayed in the market between 1999 and 2002, changes in physician entry and exit do still affect existing physician/patient relationships and could explain in part a persistently small share of beneficiary complaints about access problems. Nevertheless, the number physicians treating Medicare patients has increased.

Still using summary claims data, we also looked for trends in the number of different patients physicians saw, that is their beneficiary caseloads. Our analysis shows that median Medicare patient caseloads grew by 23 patients between 1999 and 2002 and essentially steady between 2001 and 2002. In this type of analysis, we look for signals of access problems and the increasing or steady caseloads that we see here do not signal to us that patients, on average, are having more difficulty finding a

physician or scheduling appointments.

So our median case analysis does not suggest a decline in access.

We also looked at concentration of patients to physicians. Changes in the concentration of patients to physicians between 1999 and 2002 shows that the concentration has remained extremely steady within carrier areas. Carrier areas are roughly equivalent to states. This steadiness suggests that the task of looking for a physician who is taking Medicare patients did not get any harder over the study period as the distribution of caseloads among physicians in each carrier area is virtually unchanged over the study period.

To supplement our information on physician supply, we also look at some other less direct measures: physician rates of signing Medicare participation agreements and the share of allowed charges for which patients accepted assignment. The share of physicians signing participation agreements with Medicare increased slightly to 92 percent in 2004. Assignment rates have remained high. Keep in mind, however, that physicians report that they sign participation agreement and accept assignment to take advantage of several

associated benefits. Chief among them is that they can receive payments directly from Medicare rather than collecting the entire payment from the beneficiary. For many physicians, this convenience makes it worth it to them to forego the small increase in payments that they would receive if they balance billed.

In our payment adequacy analysis, we look at changes in the use of services by Medicare beneficiaries. As we look at claims data through 2003, we do not see decreases in volumes, at least among broad categories of services shown at this chart. Across all services, volume grew about 5 percent between 2002 and 2003. Among broad categories of service growth rates vary but all were positive. As in past years, imaging and tests grew the most. From 2002 to 2003 the imaging growth rate was 8.6 percent per beneficiary and the growth rate for tests was 9.4 percent. These rates are slightly lower than the 2001-2002 rates, but they're still quite high.

In our analysis, we do see some decreases in blamed for specific services but it's not clear that the decreases are a sign that payments have become inadequate. In general, the decreases that we see are quite small and

they follow rapid increases in previous years.

One small increase I'll mention, which is really only about 1 percent, that we want to keep our eye on is new patient visits for evaluation and management. This small decrease indicates that beneficiaries are, on average, seeing slightly fewer new doctors. Although average annual growth for these services has historically been low, a decline is unusual. Although this slight decline could suggest some difficulty making new appointments, it could also suggest that beneficiaries are satisfied with their doctors and are thus seeking new ones less often. Overwhelmingly however beneficiaries, on average, have continued to use more services each year.

Another factor in our payment adequacy analysis is usually a comparison of Medicare's payment rates for physician services with average private insurer -- is the comparison that we usually do between Medicare payments and private insurer payments. Unfortunately, attaining the private payer data has taken more time this year than in past years, so we expect to be able to present our private payer comparison analysis in January.

So next I'll move on to the second part of our

adequacy framework, changes in cost for 2006. The preliminary forecast for input inflation is an increase of 3.5 percent as provided in CMS's medical economic index, what we call the MEI. As you know, within this total, CMS sorts the specific inputs into two major categories: physician work, and that includes salary and fringe benefits allotted for physicians, and that's expected to increase by 3.4 percent; and physician practice expensive, which is expected to increase by 3.6 percent. That includes nonphysician employee compensation, office expenses, drugs and supplies, medical equipment and PLI, which is forecast increase by 8.4 percent.

Some physicians, particularly those practicing in certain geographic areas and those whose specialty includes high-risk procedures, report PLI premium increases that are much higher than what is forecasted in the MEI. Recall however that the fee schedule is Medicare's primary tool for reimbursing services differentially to account for PLI premium variation by service and geographic area. Indeed, the final rule for 2005 physician fee schedule increased the PLI relative value units for many surgical services and other procedures based on new premium information.

The other factor that we consider in our input cost analysis is productivity growth. Our analysis of trends and multifactor productivity suggest a goal of 0.8 percent.

So for your discussion this draft recommendation before you is similar to the one in our previous March report. The Congress should update payments for physician services by the projected change in input prices, less 0.8 percent in 2006.

Drawing on the numbers from the previous slide, we would have a preliminary update of 2.7 percent for 2006, which is similar to the modest increase Congress legislated in recent years.

The beneficiary and provider implications, there's no changes is meant -- when we say no change here for the beneficiary and provider implications, what we mean is that this update would preserve beneficiary access to care and maintain payment adequacy to providers. For spending implications, any increase in physician payment would increase spending relative to current law because existing law, as it stands now, calls for a decrease in payments for 2006 through the SGR. On that same note, we don't present a

five year impact estimate because under current law any change in the update would be taken out in subsequent years.

So for your discussion I'll recap just a couple of points. First, the access, supply and volume measures suggest that access is good for the majority of beneficiaries. Second, recall that the MMA included added payments to physicians, such as bonuses for scarcity areas and establishing a GPCI floor over and above 1.5 percent updates. These additions are all in place throughout 2006. Keeping these points in mind, the Commission may want to discuss a lower update for 2006.

That concludes my presentation and I'm happy to answer any questions.

MR. HACKBARTH: Let me just expand on the final point. Last year the legislative update or the update for this year was the 1.5 percent. I think we actually noted in our report last year that if you took the 1.5 percent and then combined it with a GPCI floors and the like, that the net increase in dollars going into physician payment was obviously higher than the 1.5 percent and not that far off of our recommendation of a MEI minus productive; is that right?

MS. BOCCUTI: I think, to have the record straight, the chapter didn't make that connection explicitly.

MR. HACKBARTH: Oh, we did not. I remember we discussed it.

MS. BOCCUTI: We presented the timeline of when the MMA, the bonuses and the GPCI floor, et cetera, when they were in effect. We noted that they occur over and above the 1.5 percent update.

MR. HACKBARTH: So the GPCI floor -- the 1.5 update expires and it is not in effect in fiscal year 2006, the GPCI floors continue how long into the future?

MS. BOCCUTI: Through 2006.

MR. HACKBARTH: The end of 2006.

MS. BOCCUTI: Well, it's calendar year 2006, so there's a piece of it in fiscal year 2007.

MR. HACKBARTH: Thanks for the clarification.

DR. NELSON: I think I'll say this for the fifth time in five years that to me, as a physician, using the Bureau of Labor Statistics multifactor economy-wide productivity growth makes absolutely no sense for a segment of the economy that productivity may very well drop as a

product of transitioning to an electronic health record. While I understand the theory -- well, I don't understand the theory. I would much prefer that we left productivity out or that we based it on some surrogate for productivity for Part B services.

DR. SCANLON: I know we've talked about how the SGR has gotten out of whack due to errors in the past and then also the interventions that have tried to deal with those errors without changing it fundamentally, as well as the signal that it's not sending to individual physicians. But at the same time, I have maintained a concern about the fact that we need to send a signal about what's happening with respect to the volume of services and the fact that physician services are unlike hospital care or some of the other services in Medicare in that the volume precludes us looking carefully at them, though our recommendation earlier we are proposing to at least start in that direction. But that's going to be contingent upon having the resources to do it.

I just wonder if we were to start the SGR today or a formula you like it today and forget about the past errors, what would be the recommended increase? Not

necessarily recommended, but what would be the resulting increase in fees in 2006 and how would that compare to the MEI minus the productivity factor?

Because I note this volume increase continuing over all this period. I'd like to know what would have been the implications of that if the SGR was applied?

MR. HACKBARTH: What would the SGR formula have produced if we hit the reset button?

DR. SCANLON: Hit the reset button and started it at the latest possible point we can. Factor out all the errors, factor out to congressional interventions and think about it.

MR. HACKBARTH: Do you know the answer to that?

MS. BOCCUTI: No. We can expound on that but Kevin has a long history of working on this issue and happens to be sitting at my left. And if he wants to add anything.

DR. MILLER: To rescue Kevin, if I understand what your question is are you asking what the SGR would produce if just say the last year was in place?

DR. SCANLON: Right. If we started -- and I'm not sure exactly which years to use. But let's say we took 2003

fees and we looked at what would happen with respect to the change in the SGR factors, taking into account 2002 to 2003 volume growth, what would be the resultant increase for 2004? I think we can do it at a very aggregate level.

DR. NELSON: Well, if you believe in the behavioral offset, the volume would have gone up because payments per service would have gone down.

DR. MILLER: You're asking what the update would be.

DR. SCANLON: I'm asking what the update would be, and I'm seeing that volume is going up but I'm wondering what would have been the restraint on fees that would have been introduced by the SGR in the most current period.

DR. HAYES: This is just a rough approximation but we know from the work that's been done by the actuaries that the -- what we would want to do here is to contrast the volume growth that's shown on this slide here with the now 10-year moving average of GDP growth. And any difference between the two would represent a violation of the target. It would mean that volume growth has exceeded the target.

My recollection of the 10-year moving average of GDP growth is that it is in the area of 2, 2.5 percent,

somewhere in that area. And volume growth 2002 to 2003 was somewhere close to 5 percent. So we're looking at that kind of a difference that would --

MR. HACKBARTH: What about the beneficiary growth? Number of covered beneficiaries? That was per beneficiary.

Just to be clear for the record about this, Bill, the problems that we have had with SGR aren't limited to the fact that it's produced some bad numbers because of errors and forecasting problems and all that stuff. They're much more fundamental than that. In fact, we first recommended repeal of SGR before the cuts occurred because we thought it was a fundamentally flawed mechanism. It wasn't the dramatic cuts that moved us to that position.

The principal objection, and we had a list of four or five, but the principal objection is that it applies across the board to all physicians regardless of their individual performance, and that makes it unfair. But equally important, it makes it utterly useless as a tool to motivate changes in behavior. And so that's the long-standing MedPAC critique of SGR, not just the bad numbers it produces.

DR. SCANLON: And I tried to acknowledge that by

saying that among its problems was it didn't send signals to individual physicians. But on top of that, certainly the discussions these days have been dominated by the errors and the fact that there's been the interventions and the fact that to get back on the SGR path as legislated is virtually inconceivable.

MR. HACKBARTH: Other comments? Questions? Okay. Thanks.

The last item is some physician payment reform issues. Joan?

DR. SOKOLOVSKY: I guess much of what I'm going to say has come up in discussion in the course of morning, but am presenting a new idea or an idea that's new to Commission discussions today. The chair asked me to present an animated discussion because it was at the end and it was new. I think he was talking about my presentation but I chose to take him literally. So I ask you to keep at least one eye on the screen as I go through this.

The Commission has long recognized that the current Medicare physician payment system does nothing to incentivise coordinated evidence-based medical care. The system does not reward quality care nor recognize when

services provided are inappropriate or inefficient. Today we have reviewed strategies that Medicare can use to encourage the use of efficient evidence-based medicine. Some of these strategies were developed and have received considerable testing in the private sector.

The Commission has spent considerable time analyzing three of these strategies: paying for performance, measuring physician resource use and controlling inappropriate growth in imaging services. The Commission, in fact, in the past two days has considered recommendations on the use of these tools. The other two strategies, creating separate volume targets for accountable defined groups of physicians and recalibrating prices for physician services, are newer to our agenda. At this presentation we will discuss some of the policy and design issues that must be considered if Medicare were to implement separate volume targets. In future sessions we will analyze issues around the pricing of Medicare physician services.

We recognize that none of these tools is sufficient to solve current budgetary problems that have been made worse by the payment system but believe that they each have the potential to improve both quality and

efficiency within the program. This should look familiar to you, the volume of physician services provided to Medicare beneficiaries has been growing steadily since the Congress established the physician fee schedule. The per capita volume of physician services used by beneficiaries increased by more than 30 percent between 1993 and 1998. Our work on physician volume growth demonstrated that volume growth has accelerated in recent years and in the four years from 1998 to 2003 per capita growth in the volume of physician services increased by nearly 22 percent.

While some of this volume growth undoubtedly contributed to the health and well-being of beneficiaries, for example increased use of preventive services, other increases probably did not. And as many people have already mentioned today, the work of Wennberg, Fisher and others has shown wide variation nationally in the volume of physician services. Their research has shown that after we control for input prices in health status the volume of physician services is driven partly by local practice patterns and partly differences in physician supply and specialization. Greater volume is often not associated with any demonstrable improvement in health outcomes.

Because of rapid growth in the volume of physician services in the 1980s Congress established an expenditure target for the fee schedule based on growth in the volume of services. Problems with the initial standard led to its replacement as part of the 1997 Balanced Budget Act. That law established the sustainable growth rate, or SGR, as the new expenditure party for Part B services. The SGR is based on the number of beneficiaries in fee-for-service Medicare, changes in input prices, the effects of law and regulation and gross domestic product. The GDP, the measure of goods and services produced in the U.S., is used as a benchmark of how much growth in volume society can afford. The basic SGR mechanism is to compare actual spending to target spending and adjust the update when there is a mismatch.

Criticisms of the SGR are widespread. Some analysts focus on how it is calculated and what services it includes. For example, many have suggested that prescription drugs should be removed from the expenditures used to calculate volume growth. Prescription drug share of expenditures that are subject to the SGR have almost tripled over the last seven years.

Similarly, although the effects of changes in law

and regulation are included in the SGR calculation, increased utilization caused by national coverage decisions generally are not. CMS may have the authority to address such issues administratively and commissioners may want to discuss these issues.

Another criticism concerns the pattern of unrealistic negative updates that the SGR will require unless the Congress acts to prevent implementation. For purposes of this discussion, we do not address the scheduled string of negative updates. We recognize that this has tremendous budgetary implications but we do not believe Congress will allow seven years of negative updates for physicians.

The focus of this presentation is more conceptual. MedPAC has consistently raised criticisms about the SGR, both when it set updates above changes in input prices and below changes in input prices. And our criticisms are based on the following. Most importantly, it's flawed as a volume control mechanism. Because it's a national target there is no incentive for individual physicians to control volume. In fact, in the short-term physicians may have an incentive to increase volume.

It's inequitable because it treats all physicians and regions of the country alike, regardless of their individual volume influencing behavior. It creates no incentives for physicians to develop structures of care that coordinate beneficiary care across multiple physicians and sites of care. And lastly, it disassociates payment from the cost of producing services.

If Congress determines that budget concerns make elimination of the SGR impractical, multiple volume target pools could be a way to minimize the worst aspects of the SGR, the lack of individual incentives to control unnecessary volume. Congress could create an alternate pool for some physician groups with its own expenditure target. Physician groups would voluntarily apply for inclusion in the alternate pool. Services provided by members of groups accepted into the pool would be aggregated in a separate pool with its own expenditure target.

In order to participate in this pool the group would have to meet certain criteria. The focus would be that the group have a means of organization, accountability and commitment to the use of evidence-based medicine. Some possible more specific criteria could be the use of clinical

information technology, the use of systematic quality improvement techniques, the development of processes of coordinated care for patients with multiple chronic conditions and especially their willingness to be part of a collective, transparent, monitoring and improvement process. CMS could deem an entity to assure that groups meet these standards.

We can talk about what kind of groups could join the alternate pool. Multispecialty group practices we would see as a model for the kind of groups that we would anticipate wanting to join. There are currently over 600 multispecialty group practices with more than 50 physicians in the United States. They are located in all parts of the country in both urban and rural areas. Among those groups those such as the Permanente Group, the Mayo Clinic, the Marshfield Clinic and Geissinger, they have adopted techniques to bring up to date medical science systematically to the practice of medicine. They monitored the impact of these techniques on the outcome of care for patients and many have electronic medical records and other information technology.

But importantly, the pool would not be limited to

these groups. The goal would be to make the criteria for participation in the alternate pool high enough so that it provides incentives for physicians to develop organized processes of care but not so high that certain kinds of physicians -- for example rural physicians -- would automatically be precluded from joining.

Other possible organization types could include IPAs and other smaller groups of physicians who have developed alliances among practices often to contract with health plans. Similarly, single specialty practices could affiliate with other groups. These organizations could be adapted to share information and resources.

Another possibility, particularly in rural areas, could be the medical staff of a hospital. In either case, the groups would likely have to develop organizational structures to meet the accountability and communication standards that would be necessary for inclusion in the alternate pool.

Clearly, this idea raises many design and administrative issues. One set of questions is about how the target should be set. It could be the same as today, based on GDP. Alternatively, targets could be based on the

actual experience of the groups in question. Targets could be different in regions where volume is already high. They could also take into account cases where more efficient and effective physician care might reduce hospital spending. But we would emphasize that the policy is about controlling unnecessary volume.

Decisions about the types of groups that could participate in the alternate pools also would have administrative consequences. Individual physicians would have to decide whether they chose to affiliate with the newly reorganized entity. Administratively, members of the group would have to establish identity codes so that CMS could measure service use within the group. And at a minimum, CMS would have to develop processes to measure the volume of services provided by the group and its continued adherence to the criteria for membership in the alternate pool. Recall that some of these issues have already been discussed in our presentations on pay for performance and measuring resource use.

One of the most critical design issues concerns the number of alternate pools that should be established since one of the key goals of the policy is to link

individual incentives to control unnecessary volume with payment.

MR. HACKBARTH: This is a MedPAC moment here. History is being made.

[Laughter.]

DR. SOKOLOVSKY: It would make sense to have smaller pools where physicians had more ability to influence the behavior of their peers.

[Laughter.]

DR. SOKOLOVSKY: I have to stop here and give all credit to Chad, who did this.

On the other hand, larger pools would be easier to administer and would likely result in more stable estimates of volume growth. Because of the importance of geographic differences in practice patterns it might make some sense to create regional volume pools. Under this scenario areas with relatively conservative practice patterns, like the upper Midwest, could have separate volume targets from higher volume regions in other parts of the country.

While this presentation really just begins to sketch how an alternate volume target could be established, many issues obviously remain. Four of the most important

are these: CMS would have to devise a way of attributing the services received by individual beneficiaries to specific pools without locking beneficiaries into receiving care from any specific group. Some health plans have developed algorithms that attribute patient care to particular groups on the basis of the percentage of care they receive from any one group. Such a methodology might be adapted for Medicare but it would likely be a more complex process. Questions to be answered would include do all of the physician services received by the beneficiary count within the pool even if only 30 percent of the patient's care was provided by group members?

Accountability will not be perfect and pools will have to deal with the free rider problem. It is to be hoped that other tools like pay for performance and measuring physician resource use can help take into account inefficient providers with inefficient groups or efficient providers who are in the basic pool. The system must ensure that groups do not have an incentive to discourage patients with high volume medical needs or discourage group membership by physicians who provide high-quality care to patients with particularly costly medical conditions. Risk

adjustment is very likely to be needed.

Finally, separate volume pools should be combined with pay for performance and other measures so that all physicians have incentives to provide high quality evidence-based medicine.

MR. HACKBARTH: Let me just pick up on a couple of points that Joan made and say a little bit more about the context. As Joan indicated, this is a very complicated concept that we're just really scratching the surface on. So what I contemplate is not that we would make a boldfaced recommendation at this point. I don't think we've thought through enough of the detail. It could be as we think through detail we may find there are insurmountable problems and it's not a good idea. So we don't want to go so far as a boldfaced recommendation.

When I had envisioned was we would have a passage in the physician chapter that would say that if Congress elects to keep some form of aggregate volume constraint, even if it deals separately with the budgetary problems and can figure out a way to fix that, that it still wants some aggregate limit on volume, that this would be a way to potentially deal with that critical problem that I

identified earlier, that the SGR working on a national basis is unfair and does not reward appropriate behavior.

So it's sort of a directional statement. We'll see what interest there is in it. If there is interest in it, then we can invest more resources and time in development. If there's no interest, particularly given all of the other things on our plate, I don't want to consume a lot of commissioner time or staff time on wasted development.

So in a sense, we're posing a question and seeking guidance.

Just one other point before it open it up for discussion. Joan, I think you said at the outset if the budget cost of repeal makes repeal impossible, then maybe look at this. But I want to be clear that I don't think this or any other reasonable set of policies will solve the budget problem created by SGR. The hole is so deep now that the set of reasonable policies that could achieve those goals is zero. It is a null set. And so somehow the budget issue needs to be addressed separately from policy. So I don't want this to be seen by any way as a way of dealing with the SGR budget hole. It just wouldn't work.

DR. CROSSON: Thank you, Joan. I think it would probably come as no surprise that I think this is a good idea. But I have no illusions that this is a simple idea. This is a complex idea, as you said. Developing this would neither be easy nor quick.

However, It's an extremely powerful idea and it's one that really goes to the heart, I think, of at least part of the volume escalation problem which has to do with appropriateness. I think again we mentioned earlier today the life's work of Jack Wennberg is a testament to that.

I think over the last number of years of my career people have said to me in various venues it's really too bad that we can't nationally get the benefit of the whole prepaid group practice experience because it seems like a nice model that has, over time, balanced quality and appropriateness of services in a good way, a way that's garnered respect and is generally liked by the patients. But of course, the whole trappings of it, the complexity of building groups and developing payment methodologies of that kind, are kind of difficult to imagine for the country. Isn't there something or some set of things that we could do to, in fact, develop some of those benefits?

I think we've talked about some things already in this session that I think move in that direction. I think the pay for performance does that. I think the development of information technology and its ability to integrate physician practice virtually moves in that direction.

I think this idea is an additional one that does that in two ways. Number one, it provides opportunities for group practices -- prepaid or not -- around the country, particular those who are not prepaid really, to deepen their own incentives to be rewarded for their capability to manage with the infrastructure they have. And right now they have no incentive. A group practice, for example that's paid fee-for-service, is in the same pool with all other physicians in the whole country, as was described. Therefore, while these practices may in fact have the capabilities to do some of the wise management of resources in this area there's no particular financial incentive. They suffer the same reduction potentially that everyone else does.

Secondly, and I think this was mentioned by Joan, is this kind of mechanism offers the potential for other physicians in looser economic organizations or in no

economic organization over time to become part of one and to began the process, combined with pay for performance and electronic interconnectivity, to be part of some sort of system -- call it integrated system or whatever you want to call it -- that, in fact, has the capability to be what we would like to say is accountable over time, which is in the interest of Medicare. It's in the interest of beneficiaries and in the interest of the Trust and all of us.

Because, in fact, it begins a process of moving towards what we might call a 21st-century delivery system, which is what we need.

So there's no illusions about the simplicity of this. It is complex in it's design. There will be a lot of concerns about it. But again, as I said earlier, prospective payment for hospital services must have seemed equally as daunting in the beginning when people began to look at that. So I would strongly support continued analysis in this area.

MS. DePARLE: I, too, find this a very hopeful discussion but don't want to underestimate the difficulty that it would engender. I guess I'm going to add to that a little bit because, among all the materials that we got

before the meeting, we got a letter -- actually addressed to you but all of us got copies -- from a group of specialty medical societies. In reading it, I thought there was a point that was made that I wish that I had made yesterday. And maybe somebody did and I just didn't hear it. But that as we go down the road of paying for performance and looking for better outcomes and quality that there might be a relationship between that and the volume of physician visits or other clinician visits that would have a very perverse interaction with what we currently have, the SGR, and maybe even what we would do down the line with the ideas that have been laid out on the table.

And I just hope that as we look at paying for performance that we recognize that in some cases it might require more doctor visits. And so then that would have a weird interaction with what we're doing. Maybe you made that point but I didn't hear it.

MR. HACKBARTH: In fact, part of our historic critique of SGR has been based just on that. Some volume is good. Some volume increases are good. Some are not. And just to treat them all as though they're problematic is just not right. And so that would be one of the challenges here

is not to arbitrarily constrain volume but have a more discriminating set of tools. And obviously the merger of this with pay for performance would be critical.

MS. DePARLE: And the merger of pay for performance with the current system, which I agree with you that there's no reasonable set of alternatives out there that can solve the SGR problem in the short-term, and to the extent that it's a budgetary problem it's a huge one come at a time when we don't need another budget problem. But assuming that it stays out there for a while, if we are moving towards pay for performance, I think we'll have to take that into account.

The second thing, Joan invited us to talk about other things that were out there, some of which the agency might do -- I forget the language you used. And so I will mention that in reading the materials that have come my way from the AMA and others about the problems with this, and actually from Chairman Thomas I believe last year, I was intrigued by this notion about what impact would it have if you took the drug spending out? and to what extent is that really under the control of physicians? And is it fair somehow to have it in there? And in looking at it, I've

become convinced that it really probably doesn't make sense to have it in there and that CMS could take it out.

I don't think that is has that great an impact on the problem in the sense that I don't think it solves the problem of negative updates or unstable updates. But I at least find that compelling. We haven't really discussed it here. But since Joan invited us to be animated and also to talk about things like that, I'm going to say that I would, at least, support that.

MR. HACKBARTH: Why don't we just spend a minute on that and I'm aware of the time and we have to move along quickly.

There are proposals floating around for taking out drugs, not just going forward but also retroactively to the beginning of SGR. And the affect of that obviously would be much larger in terms of reducing the budget hole. In fact, some people think it could largely eliminate it. I can't vouch for that. I don't have any independent verification of that.

The question that would raise from my perspective, about MedPAC endorsing that, is that as you well know we have, for a number of years, urged Congress to change the

Part B drug payment formula, which they have now done. We did that, realizing that there was a spread between the amount the physician would receive and the amount it cost him or her to buy the drugs. That is physician income. That's not drug company income, that's physician income.

And so how we would logically square our identification of that problem with saying it ought to be retroactively taken out of the SGR would be something we would need to think about.

Now people say well, it only went to certain types of physicians. I'm not sure that that's a logical basis. All various types of services only go to select specialties.

So that's a very quick reaction, not definitive one way or the other, but some initial thoughts.

We need to get through our list here.

DR. REISCHAUER: While Joan has come up with a very interesting alternative, I think it would be a mistake to go forward with a description of just one alternative, especially when there's 1000 problems in implementing something like this, no matter how attractive it is, because it will look in a way like this is our endorsement or our best shot. And probably it's best to have three things,

even if they aren't fully fleshed out, and even if they're all substantially flawed.

In that spirit I offer a flawed alternative, which we can say well, maybe this would do something but there's a lot of problems with it, too. And that would be to vary the update by risk-adjusted resource utilization. And in the 89 regions, for those that had utilization over the national average risk-adjusted, lop half a percentage point off the update.

And you'd say well, that's a little fairer than punishing everybody. And it sort of says to southern Florida, if that's a region, if you don't have a mechanism for getting your act together, get a mechanism and start talking to one another about what you can do because over the long run this things going to bite.

I'm sure there are many other equally flawed alternatives.

MR. HACKBARTH: I agree with your point, Bob. I would have no problem whatsoever with saying there are different directions. If you choose to go down the path of narrower groups of accountability, there are different ways you could cut it, just geographically or this way. My own

particular interest in this path is that my experience, even as a nonphysician, is that physicians do better working with other physicians and meaningful groups, talking about how to improve care.

DR. REISCHAUER: I don't think we should get into an argument on is Joan's less flawed than the alternatives. Probably it is. But I was just trying to think of some other things to put on the table so that we don't look like we're endorsing this.

MR. HACKBARTH: Fair enough.

DR. STOWERS: I'll be real quick. When I first heard about this there was something that just really made me take a little caution. And I think Bob's getting exactly to where I was feeling about it.

And that is, I don't doubt that we're mixing quality and volume here, and I think that's a lot of the thing that leaves funny feelings. Because one thing could cut the volume and that would be to get away from the regions of the country where the big specialty groups are that cross refer and do all of that. Because if we look at the states with the cost per beneficiary being high, it's where the managed companies have been and where all of the

large multispecialty groups are.

So the more we've organized in groups has happened and been stimulated by being in areas where we have already high expenditure. And the areas that we are least likely to have this kind of group activity is where we see the inverse reaction of higher quality at lower volume.

We say there's a dislink between the two. I can see going into this but I kind of like Bob's idea or something of targeting those areas, whether it be you get your update if you show certain cost savings and maintain volume, or whatever like that. But if you're in one of these low states for already cost per beneficiary I really wonder what the stimulus there is going to be to bring in the cost of organizing groups and all of that, just in order to get the -- I just think we're going to have to think about and be careful not to have the large states or those states with big multispecialty groups and that ability, be able to organize and get the bonus payment, leaving these other states in some kind of a pool with the high utilizers, which would put them being brought down even more.

I guess we're really going to have to look at that. I think the whole idea is fascinating and it could

probably be made to work. But I think the complexity here -- and what baseline we're going to build from, I think, is what I started to hear from Bob that I'd been thinking. Are we going to start, in the really high utilizer states, adding on a percent or two or three on what they're already getting compared to the states that have been very efficient in the care that they've been offering who may not be able to get the bonus payments? So we've just got to look at all of that a little bit.

MR. HACKBARTH: Again, I think that describing different paths is the right thing to do. I'm not sure that I would agree, Ray, with your characterization that the states with group practice are all the high-cost states. I think if you look at it on an input price adjusted, risk-adjusted basis it's mixed. I'm not going to say that they're all low-cost states but I don't think it's accurate to say that states that have group practice are high-cost states.

MR. MULLER: In the spirit of quick comments, the pools remind me very much of Part B capitation and all the pluses and minuses of that. I think hopefully, it's seven or 10 years after the demise of that capitation, and we're a

little bit better at risk adjustment. Pay for performance is a little further along. Obviously, the national geographic variation is more on our screen that it was before. So perhaps in line with the comments that have been made by Bob and others, we could go more in that direction.

One of the advantages of looking at how this compares to capitation is we at least had a reasonable run of working with that and we know what some of the pluses and minuses were. One of the big minuses is it became so tempting, since that was a tool for accountability, to throw a lot of other things into there that weren't controllable like drug costs, the expansion of outpatient imaging. So all of a sudden we had something that was working in some places reasonably well, especially in the group practices that had a long tradition of working together, the Kaisers, et cetera, the Geissingers, the Mayos. And then we started asking them to solve the problems of not just Medicare but health costs in general by throwing a lot of outpatient stuff and drug stuff, and so forth, into the Part B pools.

So I think maybe, if we think about this in a more cautious way and not expect the physician community to solve all of the problems of the health system but to take

advantage of the groups that have been created in the last 20 or 30 years, to take advantage of the maturity with which they have looked at these issues, and benefit from say the last 10 years of better thoughts about risk adjustment, pay for performance, et cetera, this might be a good way to go back.

Because I think in the longer term, some version of capitation -- I've said this before -- has to come back because it's the only way really to have professional judgment be exercised on utilization. And since there's all kinds of reasons to see that utilization is only going to keep going up because of the advances in science and technology, et cetera, we have to bring the professional judgment back into the utilization equation.

And I think capitation was something that obviously has been vilified over the last 10 years but we need some way to resurrect it and bring it back. One of the ways may be to not burden it with the burden of solving all the problems of the health care system.

MR. DURENBERGER: First, on behalf of Arnie, add to the list on the first page don't pay for medical errors or something to that effect. The Health Partners example.

I won't take it from there. You can ask Arnie or John how best to do that.

Secondly, simply a comment on the value of just proposing this variety of approaches. I think we'll get a very positive reaction from a lot of communities around the country. Particularly I think the latter one that we're calling the pools or whatever we're calling it, I would suspect we would be pleasantly surprised by the dimension that can be added to the recommendations by the provider community. Jay just gave us an example of that if we simply put it out there for people to look at.

The third thing that relates to that is the linkage that comes between the provider groups or the clinical systems and the health plans. I think as we look around the country, probably the places which you will find upper quartile on quality and lower quartile on pay, you're going to see direct linkages between the practice systems and community-based health plans.

So that is to be encouraged in the evolution of this and I think we give that opportunity to a lot of people.

DR. NELSON: I think your idea is certainly worthy

of laying out there. I'm not sure that we -- it sounded at first blush like it was the kind of thing we'd need Ira Magaziner to help organize for us.

I think it's important to remember though that about half of the physicians in the country are organized into groups of five or less. And it would be important to provide opportunities for those groups to also participate in networks. You mentioned that but I think the reality of the distribution in the small practice units really needs to be taken right at the front.

And Bob, the idea of geographic distribution differences, by that differential incentives based on geography, it strikes me that one of the primary influences that would have would be on capacity, that areas with a low reimbursement rate in comparison would have a negative inflow of providers of services over time. And that might be a good thing.

DR. REISCHAUER: I mean, we're in a sense punishing people who are overproviding, so there's no indication that there's an access problem here.

DR. NELSON: I understand that.

DR. REISCHAUER: It's just the opposite, there's

too much access.

DR. NELSON: I'm saying though that it might not be so much that you're punishing people through the lower update that the impact would really be to reduce capacity. And I'm saying that not necessarily that's a bad thing. But you also have to consider that there may be some high-cost shortage areas that would be impacted as well. Shortages in certain specialties or whatever. It might be a rural area that for a host of reasons is just relatively inefficient.

DR. REISCHAUER: This is resource utilization. It's the number of services you provide. And if you were providing well above the average for the nation per beneficiary, you know these places which never get ahead.

DR. NELSON: I'll take an urban area. There may be areas --

DR. REISCHAUER: I don't want to defend what I think has a lot of problems.

DR. NELSON: I just wanted to point out that we'd have to consider whether or not there might be impact on shortages by virtue of redistribution of services.

MR. HACKBARTH: Just to add to our list of conceptual alternatives, I think Arnie, if he were here,

might say that another one is based on the Wennberg idea of de facto delivery systems that exist around hospitals that the empirical data show that patients are shared by relatively distinctive networks of physicians who have no legal relationship to one another. And there might be multiple hospital systems within a given geographic area. So it's not the geographic model.

So for the sake of completeness, that might be a third path to add to the list.

DR. WOLTER: Just a couple of things. I think there's potentially a lot of merit in this. I think there are pros and cons to tying it directly to SGR and volume control issues which certainly would be one of the goals.

But since we're just in the brainstorming phase, my pitch would be that what we're really trying to do is incent the development of systems of care and that we're not so much trying to come up with policy that recognizes how care is organized today, but with policy that creates change in terms of how health care delivery is organized.

And in that regard, it would be very nice to pitch this around the six Institute of Medicine aims, so that reduction of waste is clearly one of the main goals but the

connecting of the dots to the pay for performance and quality and patient safety is also put together as part of this proposal.

And I would also urge us, since we're just brainstorming, to think about the next step where we might put a percent or two of the Part A pool together with some of the pay for performance pool and Part B and some of what's being discussed in this proposal in a pool so that the networks then start to include hospitals as well as organized groups of physicians so that we then truly start to be patient centered and follow the patient across these different settings of care. I think that would be very worthy.

And there is a lot of devil in these details but I, for one, think this would be doable if we put our minds to it.

DR. BERTKO: Again, just a couple of short comments supporting the concept, echoing Nick's comments now and Jay's word accountability here. I would just, having worked with the attribution issue, suggest that particularly for smaller medical groups, I've seen some that we've looked at that have five or six docs, four of whom who seem to

participate full-time and one guy who floats around with four or five different organizations. This might lead to calling out which system and which group they're in.

That's a thing to add to Joan's list now, which is would there be a lock in so somebody would be recognized for a year as part of this system or organization?

MR. HACKBARTH: A lock-in of the physician?

DR. BERTKO: Yes, into the concept for purposes of doing the calculations.

MR. HACKBARTH: Just by way of clarification, the way I had conceived of this was that from the beneficiary perspective there is no lock-in. So this is something we do within the context of fee-for-service, free choice Medicare. We have Medicare Advantage for beneficiaries who wish to lock themselves into a particular delivery system.

MR. SMITH: I'll be very brief. The devil in the detail's of Joan's plan or Bob's plan is obviously there's a lot of attribution, the free rider, baseline problems. We'll have to work at those. But I do think there's a big difference between what Joan described and what Bob described and it's universe alley. I think, building on Nick's comments, that the notion that if we're going to try

to use revision of the SGR as a way to try to build more patient-centered system practices, we really do want to include everybody.

And if you are in a high utilization area that is in trouble on day one with its utilization baseline, you will pretty quickly figure out how to work with your peers. And I don't think we want to lose the incentive power here of everybody's in rather than simply those who can take advantage relative to the current flawed SGR. We ought to look for a model which is inclusive rather than an opt-in model.

MR. HACKBARTH: Okay. Thank you very much. Thanks for the animation. It's exciting.

DR. REISCHAUER: If I could just say one thing, and this is personal here. We can't call it Joan's plan. She only agreed to do this if it was not called Joan's plan. So we need to stop that.

[Laughter.]

MR. HACKBARTH: Okay, we'll have a brief public comment period. I would urge the commenters to keep in mind that we have commissioners who are thinking about the airport, and so please keep your comments very brief and

avoid duplicate comments, please.

DR. THOMAS: My name is Suma Thomas and I am a board certified cardiologist and speak on behalf of the American College of Cardiology.

We believe much of the growth in imaging is legitimate and falls within appropriate patient care criteria. Medicare population demographics, innovations in imaging, shifts in the site of service for some procedures and the continuing evolution of medicine are obvious contributing factors to a surge in office-based imaging.

In-office imaging by a patient's physician is designed to be patient-centered, cost-effective and of high quality. Frankly, it is in the best interest of continuity of patient care. Unfortunately, the discussion on this issue has focused almost exclusively on the so-called problem of self-referral of imaging services by non-radiologists.

We are encouraged by today's discussions and ask for a thorough analysis of this issue. Credible data is needed to back up the largely anecdotal evidence derived from interviews with eight health plans and two radiology benefit managers. We feel this has been a largely one-sided

examination of the issue and there needs to be greater input from the non-radiology health care provider community.

As a physician, I am perhaps most deeply troubled by discussions and the June MedPAC report that imply imaging performed by radiologists is beyond reproach and therefore imaging performed by any other physician specialty is substandard. On the contrary, we suggest that specialty imaging such as cardiovascular imaging, which requires extensive knowledge of the heart and how it functions, may be best performed and interpreted by a specialist comfortable not only with the imaging but also with the patient and their specific health problem.

We ask you to provide a full examination of the reasons for growth in office-based imaging and to seriously consider the implications of your recommendations before sending your report to Congress. We are happy to provide the commission with any additional information and assist in any way. Thank you.

MR. RICH: Thank you, Mr. Chairman. My name is Bill Rich. I'm Director of Health Policy for the American Academy of Ophthalmology. I'm also Chairman of the RUC, the Relative Value Update Committee. I'm only going to wear my

Academy hat today.

The first, we are not privy to some of the resource studies that you have in your book, but having been a data geek and looked at the claims data in Medicare for the last 10 years, I suspect the reason why you see dramatic changes in resource allocation per physician is the same reason you see in a number of audits given to geriatricians. Your numerator is probably very, very granular, ICD-9 and then diagnosis.

The problem is with any resource allocation to physician there is no granularity to the denominator. There's only one claim identifier for an ophthalmologist. We have six specialties. So within general ophthalmology, we average about 5 percent diagnostic tests per individual. A retinal ophthalmologist will order about 50 percent.

So I think that most of the allocation studies per physician are flawed because we do not have the ability to identify subspecialties.

Secondly, if you look at the volume data, I think there's some good reasons to see it expand, some good bad and some bad. The good reasons are, to go back to Ms. DeParle's comments, there are actually studies that show

that new performance measures do lead to increases in utilization. The National Eye Institute looked at a period where there was a 7 percent increase in volume of Medicare beneficiaries. Working with primary care we developed treatment protocols for diabetics and macular degeneration, dramatically decreased the effect of those disease on blindness. But if you look, there was a threefold increase in office-based visits and diagnostic codes directly related to those ICD diagnoses in an eight-year period. So you had a threefold increase. I would encourage the staff to look for other examples of that. That's a good cause of volume increase.

The bad one is, to go back to Dr. Scanlon's point, is economic. We created dramatic economic incentives for diagnostic testing and imaging. And if you look at 1998, we moved to a single conversion factor. We had a 16 percent increase in imaging and testing. The practice expense distribution led to somewhere between a 30 to an 80, sometimes over 100 percent increase. So indeed, we have created tremendous economic incentives to do testing.

And the last thing is, that's borne out in the RUC, where we've seen, if you look at the first five years

of the RUC, the volume of codes that are brought and now being offered to the public. There's a 50 percent increase in the number of codes the last five years that are really diagnostic and testing. The reason is we do not have a good way to do good technology assessment.

Ms. DeParle couldn't do it at CMS because of political pressures. The specialties are getting sued when we try to do it. So I would encourage the commissioners as a future project to look at how we can better address technology assessment in the future.

One point of information for Mr. Smith, all those incidents of rental and things are regulated very tightly in the OIGs. There are certain safe harbors. And if you want to look at where scans are going overseas, you look at independent testing facilities. That's how they're done. Thank you.

MS. WALTER: Hi, Deborah Walter, the Association of Community Cancer Centers.

While the data that Cristina was showing to support her arguments on payment adequacy serves as a good baseline, it appears that MedPAC is making a general characterization that everything here is okay in terms of

patient access and physician exit and entry. But what I find troubling here is that this discussion completely ignored the changes to how physicians will be reimbursed for 2005 given the implementation of the MMA. And the concerns that certainly the oncology community anyway is expressing over their ability to continue to be able to provide services to cancer patients.

There has been a lot of discussion about whether or not there will be a mass exodus at some point of physicians. And again, I think that having this kind of analysis really is done in very much a bubble and it's very disingenuous to make statements as global as these without at least referencing the MMA and the potential implications of this going forward in terms of physicians willing to stay in the system.

MS. MELMAN: Hi, my name is Diane Melman and I'm speaking on behalf of the American Society of Echocardiography.

I want to again reiterate very briefly the self-referral slant to these discussions is very, very disturbing. The only evidence that has been cited by staff is a more than 10-year-old study that preceded the Stark law

and that has been discredited. I'd be delighted to -- we have spoken with staff about this and would be delighted to speak with them again.

The areas of growth, of major growth, MRI and CT, the most expensive technologies and the most extensive growth, are not the areas where physician ownership in-office ancillary testing is going on. It's mainly in ultrasound. it's mainly in CT. And it's, to some extent, in nuclear cardiology. I would ask that the commission take an objective look at where the growth is and to very clearly distinguish issues of utilization from issues of quality. Mixing those two up leads to very mixed-up public policy and ultimately denial of access to appropriate care.

Accreditation and credentialing, the American Society of Echocardiography very, very strongly supports accreditation. However, accreditation is not all vanilla. Accreditation has a very, very significant economic downside at the accrediting agency, as in the case of MRI and CT, is associated with a particular specialty. The only accrediting organization in MRI and CT is with the American College of Radiology. The published journals of the American College of Radiology specifically indicate that

credentialing and accreditation can and, in some cases many authors have said, should be used to keep non-radiologists out of the specialty.

Before making any recommendation on accreditation or credentialing, I would ask this commission to look very clearly at the practicalities of handing that over to a private group.

Finally, to say that accreditation and credentialing are without cost is not correct. Any hospital administrator can tell you that accrediting and credentialing is with cost. It might not be cost to the Medicare program. It is cost to providers. It is cost in terms of time. It is cost in terms of administration. And it is cost in terms of trouble. I would very, very strongly urge you to rethink and think very clearly about the idea of getting the Medicare program into a credentialing situation which, at any local or national level, has the very strong potential to result in turf wars run amok.

Thank you.

MR. HACKBARTH: Okay. We're finished.

Just one reminder for the commissioners about the physician payment issues. We do have mandated reports now

in progress on the access to oncology services issue. And so you will be hearing much more about that in the coming meetings.

[Whereupon, at 12:20 p.m., the meeting was adjourned.]